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Title: Clinicians in leadership: To what extent does clinical leadership influence the delivery of NHS Wirral's provider services

Date: June 2010

Originally published as: University of Chester MBA dissertation

Example citation: Cooper, L. (2010). *Clinicians in leadership: To what extent does clinical leadership influence the delivery of NHS Wirral's provider services*. (Unpublished master's thesis). University of Chester, United Kingdom.

Version of item: Submitted version

Available at: <http://hdl.handle.net/10034/108538>

**CLINICIANS IN LEADERSHIP; TO WHAT  
EXTENT DOES CLINICAL LEADERSHIP  
INFLUENCE THE DELIVERY OF NHS WIRRAL'S  
PROVIDER SERVICES**

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A dissertation submitted in partial fulfilment of the requirements of the University of  
Chester for the degree of Masters of Business Administration

**CHESTER BUSINESS SCHOOL**

**JUNE 2010**

## **Acknowledgements**

I would like to thank several people whose valuable time and energy made this dissertation possible:

Firstly, to the staff of NHS Wirral's Provider Services who participated in this research and who on a daily basis prove why the NHS is something to be proud of.

To my boss John South, whose support, guidance and encouragement got me through it, I can now get on with some proper work!

To Steve Page, my supervisor who opened my mind to Creative Thinking and made me realise I made things more difficult than they needed to be; a truly lovely man.

To Louise, Sarah and Clare for their friendship and support – we did it!!

To my best friend Rachel, who on a cold and wet March morning provided inspiration in her own unique way.

Finally to the two loves of my life:

My husband Gerard, for love, chocolate and ruthless editing and more importantly for believing in me when I doubted myself and marrying me in the middle of this!

Ruby the naughty Beagle, for snoring at my feet (silent encouragement!) and long walks on the beach to clear my head. I love you both.

Thank You.

## **Abstract**

The importance of Clinical Leadership in the delivery of high quality healthcare is well documented (Department of Health (DH), 2007, 2008a, 2008b, 2009a) and now widely acknowledged as being a driver for change within the National Health Service (NHS). This research investigates the influence of Clinical Leadership on the delivery of NHS Wirral's Provider Services.

NHS Wirral Provider Services is a large provider of community based healthcare to the registered population of Wirral (340,000 population) and has an annual budget in excess of fifty-two million pounds

In order to create a conceptual background and framework for this research, the concepts of Leadership and Clinical Leadership are explored in the literature review, which includes analysis of the current contextual backdrop of driving forces affecting Clinical Leadership which support the organisational importance of the research.

The research utilises an interpretative phenomenological approach and a combination of inductive and deductive techniques to create the research instruments, which include semi-structured interviews and a focus group. Within-method triangulation of data is achieved which supports the validity and reliability of the findings and subsequent conclusions presented.

Following data collection and analysis, the research highlights a number of issues within NHS Wirral's Provider Services relating to Clinical Leadership. Consequently, the Author concludes there is an understanding of Clinical Leadership within NHS Wirral's Provider Services at the time of this research. However it is difficult to ascertain to what extent Clinical Leadership may influence the delivery of NHS Wirral's Provider Services.

The report finishes with recommendations based on the research, which if addressed, will contribute to the development of Clinical Leadership and its potential influence on the delivery of NHS Wirral's Provider Services.

## **Declaration**

This work is original and has not been submitted previously for any academic purpose.  
All secondary sources are acknowledged.

Signed:

Date: 3<sup>rd</sup> June 2010

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## **1.0 Chapter One – Introduction**

### **1.1 Background to the Research**

The National Health Service (NHS) is the public service most valued by the British people (Department of Health [DH], 2000) and is a complex system. The importance of Clinical Leadership is recognised early on in its development by Anuerin Bevan who identifies “*As professional men and women use your skills, judgement and leadership without hindrance*” (Bevan, 1948, p.6).

The case for Clinical Leadership within the NHS is first articulated within Commissioning a Patient-led NHS (Department of Health [DH], 2005) and reiterated in the Operating Frameworks for 2006/07 and 2007/08 (DH, 2006 & 2007). These documents clearly state that Clinical Leadership across all organisations is the key to successful change in the delivery of healthcare.

Further publications such as the Operating Framework, 2008/2009 (DH, 2008a), Lord Darzi’s report: High Quality Care for All (DH, 2008b) and Transforming Community Services (DH, 2009a) all acknowledge and advocate the need for Clinical Leadership to bring about change within the NHS, with it being the responsibility of staff at all levels to facilitate the development of Clinical Leadership within their organisations and the wider NHS environment. These documents further expand the concept of fundamentally changing the way in which healthcare is delivered through the development of Clinical Leadership.

With the recent publication of documents such as the Transformational Community Services Guides (DH, 2009b) and Productive Community Services (Institute for Innovation and Improvement, 2009) further expansion upon the role of Clinical Leadership is discussed. These documents acknowledge that transformational change within the NHS will only occur when those delivering care are motivated and inspired to do things differently.

NHS Wirral is a Primary Care Trust Organisation (PCT) established in 2006 whose aspiration is “*To improve health for all our residents*” (NHS Wirral, 2008a, p.1) and acknowledges that in order to deliver this aspiration, it will need to equip staff, with the skills they need to undertake this. In particular that “*We (NHS Wirral) need to ensure leaders have the knowledge and capacity to bring about continuous improvement of services and lead others in that process*” (NHS Wirral, 2008a, p.115) and ensure the

development of “*Clinical Leadership at all levels of the Organisation*” (NHS Wirral, 2008b, p.5).

Whilst nationally, Commissioning a Patient-led NHS (DH, 2005) requires that PCTs divest themselves of direct patient provision by 2008, NHS Wirral takes a unique stance towards the management of its Provider Services and incorporates an integrated approach to the provision of primary and community services. NHS Wirral’s Primary Care and Provider Services Directorate is managed by a Primary Care Management Board (PCMB) which is chaired by a non-executive Director of NHS Wirral. PCMB is responsible for the direct management of Provider Services and for the micro-commissioning of independent contractor services (General Practitioners, Dentists and Pharmacists).

NHS Wirral’s Provider Services comprises of twenty-six services, approximately 1200 staff with a budget of fifty-two million pounds and is committed to the “*Development of staff through Clinical Leadership*” (NHS Wirral, 2009a, p.3) in order to deliver safe, effective, high quality healthcare.

## **1.2 Research Question**

The issue this research addresses is what in relation to Clinical Leadership, can be acquired from the literature, which can then be applied to the delivery of NHS Wirral’s Provider Services, so as to ensure the delivery of high quality, cost effective services that survive within the current economic and social climate.

The research question considered is:

**“Clinicians in Leadership: To what extent does Clinical Leadership influence the delivery of NHS Wirral’s Provider Services?”**

The research aims are as follows:

- To critically review contemporary thinking on Leadership and Clinical Leadership.
- To investigate NHS Wirral’s Provider Services current understanding of Clinical Leadership.
- Compare and contrast the above two aims to determine the influence of Clinical Leadership on the delivery of NHS Wirral’s Provider Services.
- From the findings above draw conclusions and provide appropriate recommendations for consideration.

### **1.3 Justification for the Research**

On theoretical grounds it is important to examine the concept of Clinical Leadership from an NHS perspective, where service quality rather than competitiveness has historically been the driver for change. More recently the introduction of competitive markets has forced NHS managers to examine their own and the services they provide in terms of relevance and adaptability, so as to ensure sustainability.

The influence of Clinical Leadership within NHS Wirral's Provider Services may assist in modifying or transforming the services delivered. It is therefore important to understand what influence occurs and to discuss this further, basing conclusions on evidence found from the qualitative data collection. By conducting this research with the chosen methodology, a greater insight into the influence of Clinical Leadership within NHS Wirral's Provider Services is established, thus supporting the presentation of appropriate conclusions for consideration by the Organisation.

In addition, from a practical viewpoint, this research is particularly timely, with the appointment of the Author to a new post of Clinical Director, the remit of which is to *"Improve Clinical Leadership throughout Provider Services"* and *"Influence the delivery of Provider Services through engagement and leadership with Clinicians"* (NHS Wirral, 2009b, p.3).

### **1.4 Methodology**

By utilising a phenomenological approach to the research and a combination of deductive and inductive techniques to gain sufficient quality and quantity of data, an interpretivist epistemology style is developed.

The methodology utilises a case study strategy and includes qualitative research methods in the form of semi-structured interviews and a focus group. This approach is recommended by Morgan (1998) who suggests that pairing a complementary method with the principal method is good practice in any piece of organisational research and assists in ascertaining the accuracy, content, validity and meaning to data being collected.

These methodologies support the exploration and development of a rich understanding surrounding NHS Wirral's Provider Services current understanding of Clinical Leadership and its influence on the delivery of Provider Services.

The combining of qualitative methods within this study enables methodological triangulation to occur (Goodwin & Goodwin 1984) thus ensuring validity of data analysis. In addition all questions are linked to the Conceptual Model (Chapter Two; Figure 2.5) to support the triangulation of data, a view that Coyle and Williams (2000) argue, allows qualitative findings to provide salient data on subjective meanings.

## **1.5 Outline of MBA Dissertation Chapters**

### **Chapter One: Introduction**

This chapter introduces the background and justification for the research, including the research question and aims, with key definitions being explained.

### **Chapter Two: Literature Review**

This chapter reviews the critical points of current knowledge and provides a theoretical understanding of Leadership theory and Clinical Leadership. Identification of the research question or hypothesis directs and focuses the research. This chapter concludes with the construction of a conceptual model which is used to answer the research question.

### **Chapter Three: Methodology**

This chapter considers the chosen methodology for the research and discusses in the detail the justification for the phenomenological approach taken and the reliability and validity of the methodology used. It demonstrates processes for data collection and discusses ethical considerations.

### **Chapter Four: Findings**

This chapter presents and analyses the data collected, with reference to the research question and aims. Results are presented in summary charts, with limited reference to literature reviewed in Chapter Two.

### **Chapter Five: Conclusions and Implications**

This chapter gives a critical evaluation of the adopted methodology before considering the findings and presenting conclusions for the research aims and research question. It outlines the limitations of the research and discusses potential opportunities for further research in this area.

## **Chapter Six: Recommendations**

This chapter provides recommendations for consideration, based on the conclusions drawn in Chapter Five.

### **1.6 Definitions**

The following definitions are used in this dissertation:

#### **Clinical Leadership**

*“It is putting clinicians at the heart of shaping and running clinical services, so as to deliver excellent outcomes for patients and populations, not as a one-off task or project, but as a core part of clinicians’ professional identity”* (NHS, London, 2008, p.6).

#### **National Health Service (NHS)**

*“The NHS is the world’s largest publicly funded health service. With the exception of charges for some prescriptions and optical and dental services, the NHS remains free at the point of use for anyone who is resident in the UK. It covers everything from antenatal screening and routine treatments for coughs and colds to open heart surgery, accident and emergency treatment and end-of-life care. While some differences have emerged between these systems in recent years, they remain similar in most respects and continue to be talked about as belonging to a single, unified system”* (DH, 2000, p.16).

#### **Clinician**

*“A Health Professional engaged in the care of patients”* (DH, 2000, p.2).

#### **Clinical Service**

*“The provision of a service directly to patients or one that supports staff in the delivery of patient care”* (DH, 2009a, p.14)

#### **NHS Provider Services**

*“The arm of a PCT that provides community services including Community Nursing, Therapies, Sexual Health, Unplanned Care, Equipment and Wheelchair provision”* (DH, 2009a, p.8).



## **1.7 Summary**

This chapter introduces the research topic and sets the scene for the research including justification of the research question and aims. Definitions of commonly used phrases and titles are given for clarification with the chosen methodology briefly explained in the context of the research question and aims.

## **2.0 Chapter Two – Literature Review**

### **2.1 Introduction**

This chapter develops an in-depth knowledge of the research topic through a detailed literature review that is systematic, rigorous and facilitates full consideration of the research question.

### **2.2 Mapping the Literature**

The preliminary literature review of the research area considers leadership theory with a more focused review of contemporary thinking regarding Clinical Leadership. In addition the literature review considers theory and models of leadership and attempts to argue theory relevance and appropriateness to use within the NHS.

Creation of a conceptual model assists the Author during the semi-structured interviews and focus group data collection process, in an attempt to answer the research question.

Being applied in nature, the study is grounded in literature research and includes journal searches from *Leadership in Health Services; Journal of Leadership and Organisational Development; Journal of Health Organisations and Management*, examining in more detail Clinical Leadership and its influence on the delivery of NHS services.

Key texts include: *Jaspar, M. and Jumaa, M. (2005), Effective Healthcare Leadership; Northouse, P.G (2007), Theory and Practice; Hughes R.L., Ginnett R.C. and Curphy G.J. (2009), Leadership – Enhancing the Lessons of Experience; Daft, R.L (2008) The Leadership Experience.*

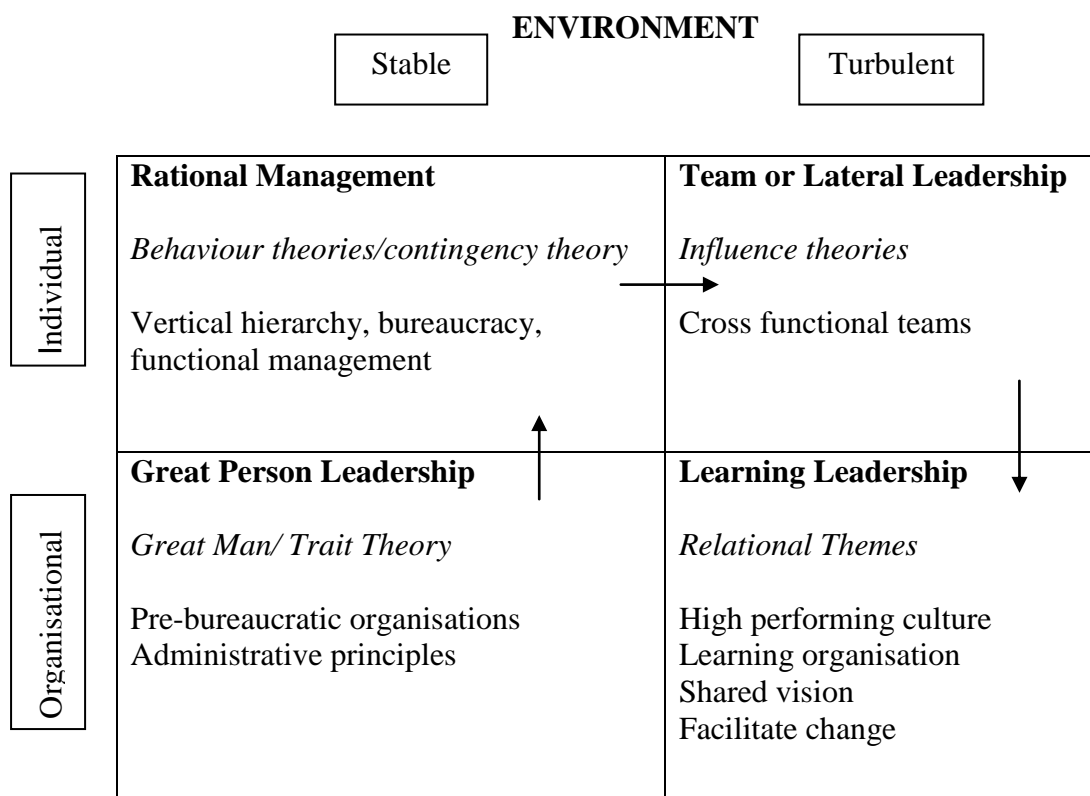
### **2.3 Leadership Theory**

Research studies concerning leadership examine a variety of perspectives over many years with much being written about leadership theory in an attempt to describe leadership and define what a leader is. Hughes et al (2009, p.6), define leadership as “*the process of influencing an organised group toward accomplishing its goals*” with Northouse (2007, p.20) stating “*....actions that focus resources to create desirable opportunities*”. Therefore, suggesting that the art of leadership concerns the skill of understanding leadership situations and influencing others to accomplish group goals,

with leadership in many organisations identified as being crucial to the development of strategy, achievement of objectives and possible competitive advantage.

Leadership theory has evolved over centuries as attitudes, values and beliefs have changed. Figure 2.1 – Eras of Leadership (Daft, 2008) highlights the various phases of leadership theory relating to whether the environment is stable or turbulent and the scope of the leadership theory - individually or organisationally.

**Figure 2.1: Eras of Leadership (Daft, 2008)**



**Reproduced from Daft, R.L. (2008, p.22). *The Leadership Experience*. 4<sup>th</sup> Edition. Manson: Thomson South-Western.**

Figure 2.1 is useful in providing some indication of the conditions faced when explaining why theories developed at particular points in time. The Great Man theory is the most widely recognised first theory of leadership. According to this theory, great leaders are born not made and a single person has the skills, qualities and attributes inherent within them to lead successfully.

### 2.3.1 Traits Theories

The concept of Trait theory (Jung, 1923) focuses upon the idea that great leaders have particular traits or characteristics e.g. intelligence which enables them to excel as a leaders in combination with their personality. It is the traits approach to leadership, that assumes leaders are born not made, maintaining that people behave in the way they do because of the strength of the traits they possess (Stodgill, 1974; Hogan, 1991; Charan, 2007). Stodgill (1974) highlights initiative, self-confidence and personal integrity as key traits with strength of personality being acknowledged (Hughes et al, 2009) as an additional important factor that can affect leadership.

Bennis and Nanus (1997) further identify a relationship between traits and the effectiveness of leadership in respect of four specific areas. Firstly, the trait of logical thinking in respect of the ability of the leader to translate complex ideas into a simpler reality coupled with the ability of the leader to persuade others to act upon those ideas and deliver effectively. Secondly, persistence related to working long hours to succeed against all odds. Thirdly, the ability to empower others to take action and responsibility to achieve goals, whilst encouraging people to be enthusiastic and energetic in their endeavours with the final trait being self-control and the ability to remain calm and even tempered especially under pressure.

The importance of leadership knowledge is often acknowledged as being a developed personal trait in leaders. Charan (2007) highlights essential leadership skills including the ability to judge people accurately; creating and moulding a team and identifying patterns of external change to enable the setting of the right goals to place the customer at the centre of the business, whilst recognising that leaders have to be *“self aware and consider personality traits that might be holding you back from fully developing leadership know how”* (Charan, 2007, p. 89).

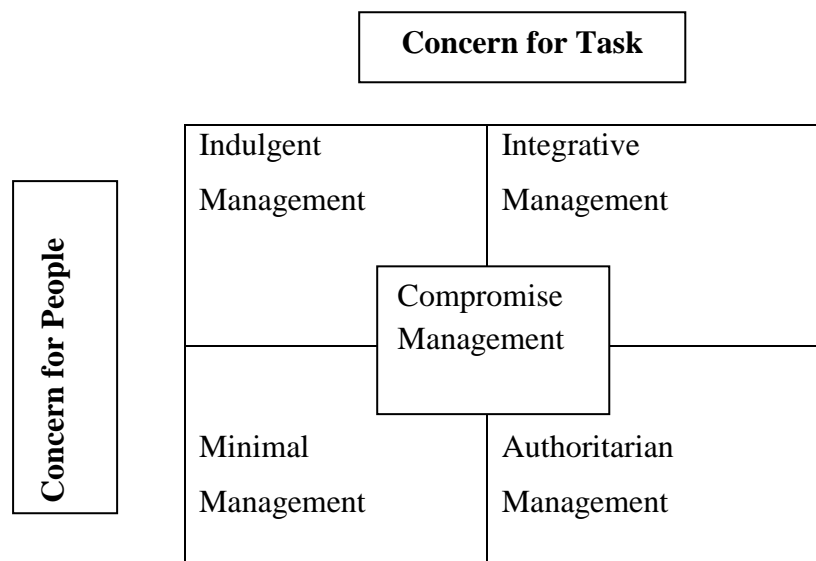
Charisma closely relates to the collection of trait theories, with Weber (1946) highlighting charismatic leadership as being leaders who exhibit a dominant personality, the ability to influence and high expectations of their followers. This theory focuses upon the leader as individual in the characteristics they exhibit to achieve outcomes. The concept of Charismatic Leadership relates to trait theory and is beginning to re-emerge as an important leadership style within both private and public sector organisations in influencing others, building networks and relationships to achieve outcomes.

### 2.3.2 Leadership Styles and Behaviours

The 1960's brought new ideas of leadership theory moving from the idea of traits to looking at styles and behaviours that could be developed in the context of the workplace. McGregor (2006) proposes the Theory XY leadership style which is based on one's assumptions of human nature. This leadership style supports that Theory X managers have a view that people inherently dislike work and will avoid it therefore; they need to be coerced and controlled. In comparison, Theory Y managers have the view that given the right conditions and support people will seek out responsibility and solve problems creatively (McGregor, 2006).

The Managerial Grid Model (Blake & Mouton, 1985) focuses upon concern for people and concern for task and is shown in Figure 2.2.

**Figure 2.2: The Managerial Grid (Blake & Mouton, 1985)**



**Reproduced from Blake, R. and Mouton, J. (1985, p.64). *The Managerial Grid III: The Key to Leadership Excellence*. Houston: Gulf Publishing Company.**

Blake and Mouton (1985), postulate that the integrative management position is the leadership approach for all situations as the manager integrates task and concern for people to produce the very best performance. However, with the grid being two dimensional it only focuses upon task and people and takes no account of other variables including context, culture of the organisation, and environment.

Tannenbaum and Schmidt (1958) suggest a continuum of leadership styles that recognises behaviour is influenced by personality, background, knowledge and experience. This model allows for interdependency with subordinates and that these may take initiative to change boundaries through interaction with external forces. As Mullins (2007) concurs, a variety of people with differing personalities and from different backgrounds can emerge as effective leaders in different situations.

The importance of the leader, follower and situation in the leadership process was first documented by Fiedler (1967) as the Contingency Model of Leadership. This theory demonstrates a relationship between styles and situational variables suggesting that group effectiveness is related to how well leadership style matches the correct situation. Fiedler (1967) proposes that there are a range of leadership styles available to a person to use and identifies whether a leader is task orientated or relationship orientated and matches their skills to the situation in question. The task-orientated leader is concerned with achieving the task and may talk negatively about people involved whereas the relationship orientated leader is concerned with people involved and establishes mutual trust and respect.

This theory highlights that the choice of style in any given situation depends upon the relationship between the leader and the employee; the characteristics of the work in terms of being task or relationship focussed and the level of positional power the leader has within the group. Leader position power is strong when the leader has formal authority and can evaluate work and reward employees as they choose, whereas leader power is weak when there is no formal authority over employees and the leader is unable to evaluate the work undertaken. In addition, the task-oriented leader is more likely to succeed where there is a clear task and there is a need for someone to take control. However, the relationship oriented leader performs highly where good inter-personal relations are required to achieve high group performance.

Hollander's (1978) transactional approach further develops and enhances the interactional framework for analysing leadership by depicting leadership as a function of three elements – the leader, the followers and the situation. Hollander (1978) proposes, that leaders are effective when they give something and get something in return and as such undertake a social exchange to leadership which involves a trading of benefits. Hughes et al (2009), support the view that leadership is a process, rather than a

position and involves something happening as a result of the interaction between the leader and their followers.

In contrast to Fiedler's Contingency Leadership Model (1967) and its underlying assumption that leadership style is hard to change and leader effectiveness is primarily determined by selecting the right kind of leader for a certain situation or changing the situation to fit the leader's style, the Hersey-Blanchard Situational Leadership Model (1969) suggests that successful leaders do adjust their styles and views. Furthermore, situational leadership theory (Hersey & Blanchard, 2001) maintains that leaders who correctly base their behaviours on follower maturity will be more effective.

Drawing on contingency theory, the model of situational leadership identifies that leadership style varies according to the situation and circumstance. People are a key part of the theory and leaders will achieve results in a variety of ways depending upon the skill/development level of the followers. The characteristics of the followers will determine effective leadership behaviour so for example where followers have low skill levels and little task readiness, the leader is likely to fail. As the skill and confidence of followers increase, the leader is more likely to succeed. Mullins (2007) concurs with this view and suggests that leadership style is the way in which the functions of leadership are carried out and the way in which the leader typically behaves towards members of the group.

### **2.3.3 Individualised Leadership Theory**

As the decades move on and further research is undertaken, new ideas of leadership and developing relationships arrive in the form of Individualised Leadership. This theory examines *“the specific relationship between leaders and each individual member”* based on a *“notion that leaders develop a unique relationship with each group member, which determines how the leader behaves towards the member and how the member responds to the leader”* (Yammarino & Danereau, 2002, p.96).

This theory focuses on the relationship and exchange by each party in the dyad. With the focal point being the emphasis on the leader being able to meet follower's emotional needs and develop their self worth, while the follower provides commitment and high performance. The success of each dyad in providing this exchange is based upon the health and quality of the relationship between leader and follower.

Daft (2008) further expands this model to chart the four stages of development of Individualised Leadership: Vertical Dyad linkage – behaviours and traits of leaders have different impacts across followers creating in and out groups; Leader Member exchange – leadership is individualised for each subordinate; Partnership Building – leaders reach out to create a positive exchange with every subordinate to increase performance; Systems and Networks – leader dyads are created in all directions across organisations and boundaries to build networks that enhance performance.

For the in-group, the leader is participative, empowering and encourages learning from mistakes whilst providing praise for efforts and achievements, whereas the out-group are given direct instructions/orders, are not encouraged to think for themselves and must solve their own problems, mistakes are criticised or punished and no praise is given for efforts. The group an employee finds themselves in is dependent upon the relationship they build with the leader and the level of trust and respect they have for each other. Individual needs are either met or unmet based upon the relationship and therefore performance will depend upon the group into which they “fit”. Taking this relationship to the next level a higher quality relationship often emerges through time with in-group members, as often the relationship is based upon employees and leaders having similar characteristics, behaviours and values but still the in and out groups remain, with different treatment by the leader and therefore differing levels of performance.

The final stage of the Individualised Leadership theory is about developing relationships across systems rather than restricting them to just immediate employees. The purpose of doing this is to create a network of relationships across the system to influence more people around the system to contribute to the success of their work area. Both the partnership building and systems/network building elements are important in the delivery of outcomes across the NHS with future developments taking into account these elements to raise awareness for participants and encourage reflection of own practice and behaviours.

In addition, this theory highlights to leaders the need to encourage self-reflection upon their behaviours with their staff and the presence of in and out groups. This view is supported by experiential learning theorists such as Kolb (1983), who states that people learn more from their experiences when they reflect on them. This can be extended to the Action-Observation-Reflection-Model (Hughes et al, 2009) which shows that



leadership development is enhanced when the experience involves action, observation and reflection.

Utilising this model of Individualised Leadership may support leaders to attend to performance issues, with Manzoni and Barsoux (2002) suggesting that leaders categorise employees into in and out groups as early as five days into their relationship. The partnership building element of the theory recommends that the leader develops positive one to one relationships with each employee to enhance performance.

### **2.3.4 Leadership versus Management**

Many have discussed the tension between leadership and management (Kotter, 1990; Tichy & Devanna, 1990), with Bryman (1996) agreeing that there may be some overlap in practical terms and suggesting that at its very simplest level, management is about organisation, planning and control, whilst leadership is about the process of influence. Kotter (1990) further expands that there is a difference between managers and leaders when deciding what should be done, developing capacity to do it and ensuring that it is done, with Zaleznick (1983) suggesting that these differences can be attributed to different personality types.

However, it is Burns (1978) who acknowledges the real difficulty in differentiation between management and leadership, by claiming that the differences are in characteristics and behaviours and as such establishes two concepts: Transformational Leadership and Transactional Leadership.

### **2.3.5 Transformational and Transactional Leadership**

Transformational Leadership has become one of the dominant themes in leadership research and development over the last thirty years. According to Burns (1978), the transformational style creates significant change in the life of people and organisations by redesigning perceptions and values and changing expectations and aspirations of employees. It is not based on a "give and take" relationship which is the basis for the transactional style, but on the leader's personality, traits and ability to make a change through vision and goals. Murphy (2005) concurs that transformational leadership energises and motivates staff to pursue mutual goals, share visions, and develop a culture of empowerment where mutual respect is acknowledged. Mullins (2007) further expands on this to suggest successful leadership involves the effective process of

delegation and is a dynamic two-way process which influences both individual and organisational performance.

Transformational leadership (Burns, 1978) is defined as the leader having the skill or ability to engage with others at all levels; empowering and motivating followers by clarifying the purpose of the organisation/task and providing a vision. A frequently used phrase within the NHS and wider public sector is “*changing hearts and minds*” (DOH, 2009a, p.8) which originally comes from Burns’ theories. Transformational Leadership is often seen as a way of actively engaging followers to be part of the change process. This approach focuses on empowering and motivating followers to take responsibility; encouraging creativity and displaying espoused values.

The work of Burns is further developed by Bass (2001), who identifies the four I’s of Transformational Leadership, these being: Individualised consideration which is the desire to learn and improve services/actions; Intellectual stimulation which encourages followers to think and show willingness to think; Inspirational motivation which encourages followers to be willing to increase effort; Idealised influence which is enacted by followers in their expressed desire to achieve and show support for the leader.

The concept of the leader being able to recognise the abilities and emotions of others is supported by Rubin, Munz and Bommer (2005) who note that transformational leaders are “*typically emotionally stable and positively engaged with the world around them... strong ability to recognise and understand others emotions*” (Rubin et al, 2005, p. 849).

Bass (1990) further expands his ideas of leadership style and influence with the creation of a Full Range Model of Leadership, which encompasses a spectrum of styles from his work. This model combines the four I’s model with the approaches of laissez-faire (non-leadership), transactional (management by exception and contingent reward) and transformational leadership (participative and delegative), and recognises the situational context of leadership and the necessity for leaders to use different styles to achieve their aims.

Building upon the theories of Burns (1978) and Bass (2001); Alimo-Metcalfe and Alban-Metcalfe (2005) suggest a UK Transformational Leadership model based on their research across both public and private sectors. This research identifies a number of essential leadership qualities including showing genuine concern for others; being

accessible to staff; encouraging questioning and curiosity within the service and the organisation; creating the conditions to enable staff to learn and develop their own leadership skills and acting with integrity.

## **2.4 Clinical Leadership**

Contemporary research to date does show that there is a distinct need for clarification of what constitutes leadership in a clinical setting, with it being suggested (Edmonstone & Western, 2002), that there is a difference between a traditional business setting and a clinical setting and therefore traditional methods of leadership may have to be challenged and adapted.

The case for Clinical Leadership within the NHS is first articulated in the publication Commissioning a Patient-led NHS (DH, 2005) and reiterated in the Operating Frameworks for 2006/07 and 2007/08 (DH, 2006 & 2007). These documents clearly state that Clinical Leadership across all organisations is the key to successful change in the delivery of healthcare, acknowledging that Clinical Leadership can assist in modifying or transforming healthcare organisations in order to maintain and improve their effectiveness when delivering patient care (NHS Alliance, 2007).

Millward and Bryan (2005, p.15), state that Clinical Leadership is essentially “*about effective delivery of healthcare at the front line*” and is considered to be an “*essential prerequisite*” in the planning of service delivery and identification of patient needs in the healthcare market. The Department of Health (2007a, p.49) concurs that “*the essence of Clinical Leadership is to motivate, to inspire, to promote the values of the NHS, to empower and to create a consistent focus on the needs of the patients being served*”. As such the development of Clinical Leadership is now seen as the key enabler to delivering high quality, cost effective patient care and sustainable change in the way in which healthcare is delivered (DH, 2009a) and the achievement of competitive advantage (Porter, 1980).

Within the NHS, there has been a significant emphasis in the past upon management rather than leadership (Edmonstone & Western, 2002) with the NHS often described using the machine metaphor (Morgan, 1986) due to the way it thinks and acts with technocratic rationality and increasingly centralised control. However, many have noted the critical importance of front-line leadership in the changing of organisational culture,

development of integrated team work and modernisation of the NHS (Millward & Bryan, 2005; Outhwaite, 2003).

Crisp (2001) reflects that “*leadership must be exercised at all levels in all settings in the clinical team and in support services and in the boardroom*”, thus supporting the theory that it is the individual clinician that can make a difference to the development of healthcare. Although it is apparent that Clinical Leadership does not necessarily take place within the hierarchical structure of an organisation, with many people operating as leaders without their role ever being clearly established or defined (DH, 2009b), the transformation of the NHS will not occur unless the majority of employees at all levels are empowered to lead in new directions (Jasper & Jumaa, 2005).

In recent years, considerable amounts of public money have been devoted to delivering leadership programmes in the NHS (Institute for Innovation and Improvement, 2006) with the emphasis upon Transformational Leadership skills being viewed as the way to develop leaders of the future. This focus upon Transformational Leadership has arisen as the majority of research published since the 1980’s which concentrates on Transformational Leadership (Jackson & Parry, 2008), with some writers conducting their research in public sector organisations and developing assessment tools for the sector upon which their results are based (Alimo-Metcalfe & Lawler, 2001).

Whilst Clinical Leadership appears to sit firmly at the core of the modernisation agenda for the NHS, as a result of publications such as Strengthening Leadership in the Public Sector (Cabinet Office, 2001) and NHS Leadership Qualities Framework (Institute for Innovation and Improvement, 2006), concern is often expressed within the public sector regarding the lack of understanding surrounding the nature of leadership and the qualities managers should possess in order to be effective leaders and deliver change (Cabinet Office, 2001; NHS London, 2008). Maddock (2002), reveals that the majority of public sector staff do not understand why change and modernisation is necessary and only a small percentage of senior managers actually knowing how to transform their services. This suggests a gap in leadership qualities and skill levels to bring about change effectively.

The impetus for leadership development emanating through the NHS has resulted in the publication of the NHS Leadership Qualities Framework (Institute for Innovation and Improvement, 2006). This framework sets the standards for outstanding leadership and can be seen in Figure 2.3. It describes the qualities expected of existing and aspiring

leaders both now and in the future and can be used across the NHS to underpin leadership development, for individuals, teams and organisations. This supports the argument (Hewison & Griffiths, 2004) that Clinical Leadership is fundamental to the sustainability of the NHS and critical to transforming service provision by demonstrating leadership that ensures the workforce at all levels are provided with the skills and knowledge to deliver high quality, cost effective services.

**Figure 2.3: Leadership Qualities Framework (2006)**



**Reproduced from Institute for Innovation & Improvement (2006, p 4). *NHS Leadership Qualities Framework*. London: HMSO.**

Whilst the Leadership Qualities Framework (Institute for Innovation & Improvement, 2006) advocates that effective Clinical Leadership is based on a collective group of characteristics, behaviours and attributes, concern is expressed (Jasper & Jumaa, 2005) that this cannot be delivered effectively given a lack of resources and investment to support change.

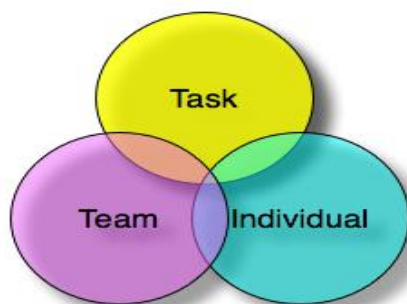
According to Cook and Leathard (2004), there are five attributes which are characteristic of Clinical Leadership; highlighting, creativity, influencing, supporting and respecting and that a successful leader will utilise all of these in order to achieve improvements in patient care. Jasper and Jumaa (2005) expand upon this to develop

their Clinical Nursing Leadership Learning and Action Process (CLINAP) Model. This model promotes the development of capability in clinicians through the Clinical Leadership process so as to ensure the sustainability of high quality healthcare performance. As with Kolb (1983), the success of this model is based upon individuals learning as a result of their experiences.

Jasper and Jumaa (2005) maintain that their model is the essence of Clinical Leadership as it supports the development of effective leadership, which positively influences performance and patient outcomes. The main challenges are at the front line of leadership and fall into the following three categories; individual, team and organisation (Jasper & Jumaa, 2005; Adair, 2005).

During the 1970s, Adair (2005) created the “Three Circles Model” (Figure 2.4) which illustrates leadership as three areas of need which are interlinked and dependent on one another. This is because individuals make up teams, teams/individuals complete tasks and without a task there is no need for a team or individual. If one element is missing or weak then the other elements will suffer. For example if the team is weak then the task will suffer and one weak individual can affect team performance and subsequently task completion.

**Figure 2.4: Three Circles Model (Adair, 2005)**



**Reproduced from Adair, J. (2005). *How to Grow Leaders; The Seven Key Principles of Effective Leadership Development*. London: Kogan-Page.**

When viewing this model in the context of Clinical Leadership it demonstrates the encouragement of ownership and empowerment at the different levels, thus encouraging issues to be resolved at lower levels. This leads participants to reflect on their own

contributions and to consider how a commitment to teamwork can enable all staff in the Organisation to be involved in strategy development and future organisational direction.

In order to transform and modernise services within the NHS a receptive and positive culture must exist within the Organisation (Scott & Caress, 2005). Organisational culture is recognised as a crucial factor in the achievement of organisational objectives (Davies, Nutley & Mannion, 2000), with Schein (2004) arguing that an essential element of leadership is the manipulation of culture within organisations. This has major implications for managers in the NHS as they have been charged with the responsibility of changing culture, creating cost effective service provision and ensuring that all staff are committed to the delivery of a quality service (Hogget, 1996). In the drive for performance improvement an understanding of organisational culture and professional subcultures is required (Lambert, 2001), this is in addition to a need to familiarise each group with the other's priorities, skills and agendas to help to achieve better teamwork and thus a better health service (Lee-Potter, 1997).

Whilst Howkins and Thornton (2002) suggest that the leader's role is to create a climate in which everyone understands and accepts the need for continuous review and change, Fitzgerald and Ferlie (2000) highlight structural changes that have produced a new category of professional managers; who are actively managing performance and providing Clinical Leadership so as to achieve change for the benefit of the Organisation. For Clinical Leadership to become embedded in the Organisation it must be viewed as implementing change which adds value to the Organisation as a whole and promotes patient care (Jasper & Jumaa, 2005).

Current thinking regarding Clinical Leadership revisits certain aspects of Clinical Leadership including the view that effective Clinical Leadership may only occur when the individual involved is from a clinical background (Kahn, 2003; Willcocks, 2005). In addition personal characteristics and their contribution to organisational success are explored further, with many examining possible gender differences in leadership style. Roesener (1990) and Alimo-Metcalf (1995), suggest that men prefer a transactional approach and have a greater tendency to use their formal power and to guard information more closely, whilst females prefer to use a more interactive style, be transformational in their approach by sharing information and power and enhancing peoples feeling of self worth using personal power. This research regarding gender

differences in leadership style may be relevant in the public sector setting as within the NHS the majority of staff are female (Millward & Bryan, 2005).

In summary, the literature surrounding leadership theory and styles is rich and diverse. Therefore, the review of literature in this chapter focuses on leadership theory, the concept of Clinical Leadership and its potential influence on organisational change and culture in the context of the NHS.

## **2.5 Conceptual Model**

The conceptual model developed for the purposes of this research (Figure 2.5), is a combination of the models, theories and ideas introduced earlier in this chapter, which provide a framework for answering the research question.

In developing a conceptual model to underpin the objectives of this study, it is crucial to identify the typology and major characteristics of Clinical Leadership, its relationship with organisational culture and the influence, if any, on organisational performance, service improvements and cultural change.

The conceptual model uses the image of a tree to illustrate the variety of literature and models considered in its formation. The symbolic representation of a tree gives a sense of Clinical Leadership being a dynamic, living and growing entity in which the “roots” are; leadership theories, Adair’s (2005) Three Circles model, culture and learning styles. These develop into Clinical Leadership qualities and frameworks and then ultimately bear “fruit” in the form of competitive advantage, development of a learning organisation and facilitation of change. The conceptual model is colour coded to provide ease of reference to the literature reviewed.

The “roots” of the tree initially consider the [Traits Theory approach to leadership \(Jung, 1923; Stodgill, 1974; Hogan, 1991; Hughes et al 2009\)](#), with particular reference to the work of Stodgill (1974) and Hughes et al (2009) who highlight initiative, self-confidence, personal integrity and strength of personality as key traits that form the basis and roots of effective leadership .

The “trunk” of the tree is developed by incorporating elements of [Adair’s \(2005\) “Three Circles Model”](#); [task, team and individual](#), and the effectiveness of integration to achieve organisational goals is explored. Alimo-Metcalfe and Alban-Metcalfe (2006) suggest that effective leaders should pay attention to these three areas of need and utilise



a collaborative approach to leadership. Schein's (2004) view that the manipulation of organisational culture is an essential element of effective leadership is considered along with the impact of organisational culture in developing effective engagement.

Building upon the above theories the conceptual model considers the impact on the development of Clinical Leadership through learning and development. This includes the view supported by experiential learning theorists such as Kolb (1983) that people learn more from their experiences when they reflect on them and that leadership development is enhanced when the experience involves action, observation and reflection (Hughes et al, 2009).

When used in conjunction with the work of Cook and Leathard (2004), who identify five key attributes of Clinical Leadership: creativity, highlighting, influencing, respecting and supporting and the Leadership Qualities Framework (Institute for Innovation and Improvement, 2006) the characteristics of Clinical Leadership are defined and provide clear evidence that these attributes, when utilised appropriately will achieve significant improvements in patient care.

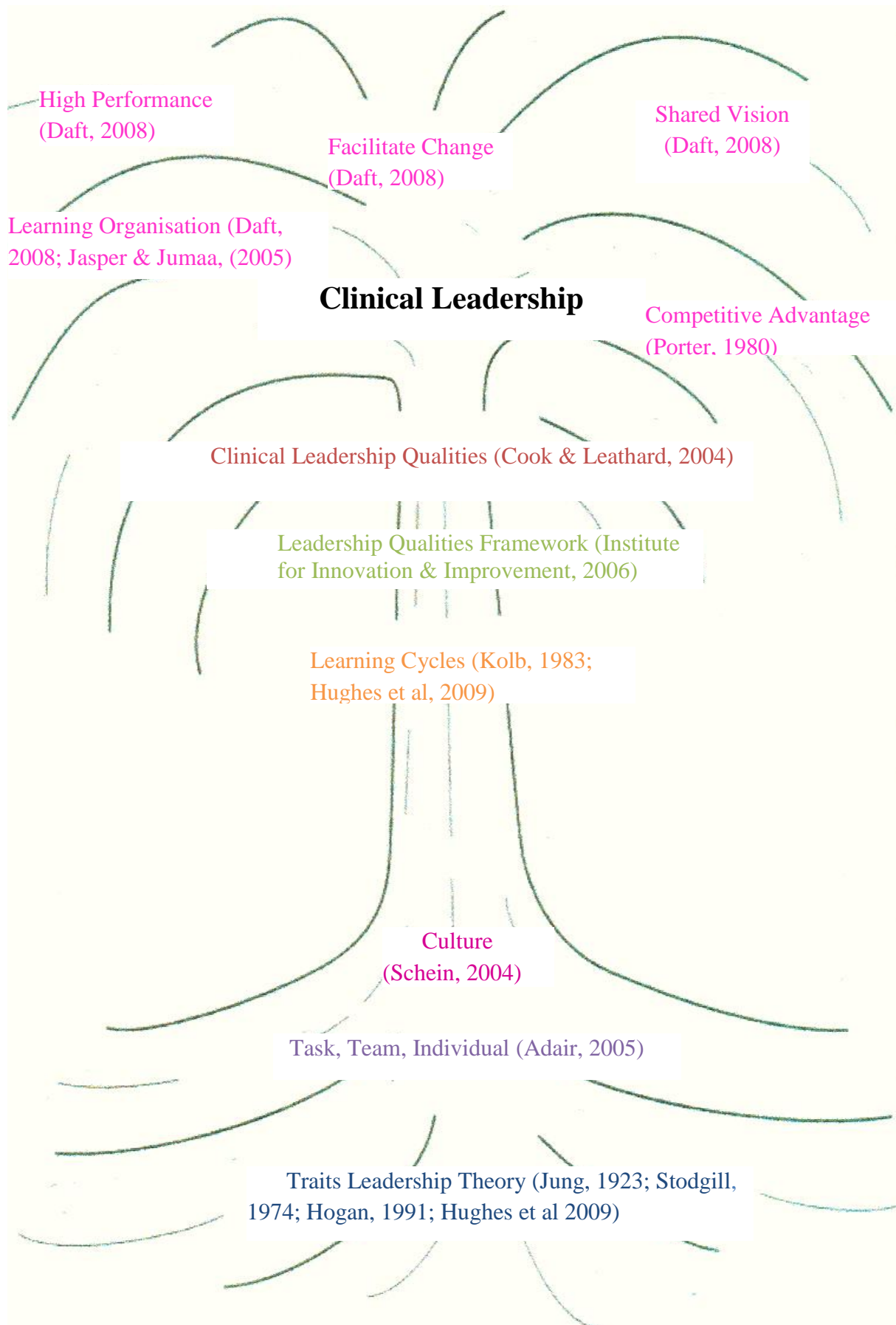
As the development of Clinical Leadership is now seen as the key enabler to delivering high quality, cost effective patient care and sustainable change in the way in which healthcare is delivered (DH, 2009a), the impact of Clinical Leadership on service improvements and outcomes (Buchanan et al, 2007) will be explored through the conceptual model. The “fruit” of the tree being the work of Daft (2008), Porter (1980) and Jasper & Jumaa (2005) who suggest that effective leadership can lead to a high performing, learning organisation which achieves a shared vision, facilitates change and the achievement of competitive advantage.

In summary, the conceptual model attempts to show how the above areas link to form the development of Clinical Leadership and consider its influence on service improvements, organisational performance and culture within the NHS. This conceptual model supports the development of the semi-structured interview questions and focus group design by linking each question to the model with consideration given to the triangulation of the data collected in an attempt to answer the research question.

## **2.6 Summary**

This chapter presents an detailed information on the research topic through a detailed literature review and the production of a conceptual model that is systematic, rigorous and facilitates full consideration of the research question.

**Figure 2.5: Conceptual Model**



### **3.0 Chapter Three – Methodology**

#### **3.1 Introduction**

This chapter considers the methodology used to collect data which will ensure rigour of findings in support of the research question and aims.

#### **3.2 Research Philosophy and Principles**

Research philosophy is informed by the way in which the researcher perceives society and the development of knowledge (Saunders et al 2009). Bowling (2002, p.119), states that every branch of scientific enquiry is based on a set of theoretical perspectives, known as paradigms, described as *“a set of assumptions on which research questions are based – or a way of looking at the world”*.

Introducing a paradigmatic framework, Burrell and Morgan (1979) describe four paradigms that can assist in the development of an understanding of organisations from a social and scientific perspective. Underpinning this framework is the belief that philosophical assumptions about society require differing approaches to the study of social science. Four distinct paradigms are created: Positivism, Phenomological (Interpretivist), Interventionist and Pragmatism. The framework provided by these perspectives allows observations to be focused and interpreted, giving value and meaning, and ultimately allowing the paradigms themselves to be re-visited and theories redesigned.

The Positivism paradigm (Burrell & Morgan, 1979) is the dominant framework utilised when the researcher wishes to investigate academic sociology and the study of organisations. Positivism is based in the sociology of regulation and approaches its subject matter from an objectivist viewpoint as positivists are concerned with understanding how organisations and society maintain order. The positivist approach argues that the truth exists independently of the people who seek it and can be obtained through logical deduction or the collection of data (Jankowicz, 2005). A key feature of this approach is the researcher's independence from the subject of the research (Remenyi, Williams, Money & Swartz, 1998).

The Phenomological/Interpretivist paradigm (Burrell & Morgan, 1979), views the social world as an emergent social process which is created by the individuals concerned. The paradigm questions the validity of organisations in the real sense, suggesting that their

very existence is purely conceptual whilst social reality is seen as little more than a network of assumptions and shared meanings. Interpretivists take a subjective view of reality and their concerns focus chiefly on how individuals perceive organisations and society, and how society and organisations maintain order, often seeking to understand the source of social reality. In support, Richardson (1998) claims that the phenomenological viewpoint embraces that which exists but does not lend itself to scientific measurement, whilst Titchen (2005) suggests that phenomena can be researched directly by exploring human knowing and indirectly by exploring human being, indicating suitable data collection methods as observation, unstructured interviews, story-telling, reflection and video recordings.

Phenomenology is based on the paradigm that reality is multiple and that social laws are characterised and recognised by their meaning to members of society, so to use the methods of positivism would distort this reality. To this end, phenomenological researchers adopt a person-centred, holistic perspective, generating an in-depth account, which presents an expansive picture of the participants' reality. Phenomenological researchers use structured and unstructured observation and communication tools to collect data, in the form of words, which is then analysed to present individual responses, descriptive summaries, or both. The purpose of the analysis is to arrange the data into a meaningful, individualised interpretation or framework that gives a rich and thorough description of the phenomena being studied.

It is important to consider these paradigms in the context of methodological choice, with Holden and Lynch (2004) suggesting that when choosing an approach, the researcher needs to make a number of core assumptions concerning the dimensions of the nature of both society and science. Society can be viewed as evolving through either regulatory or radical change. In the former, society is viewed as evolving rationally in a unified and cohesive manner, whereas in the latter the view is of constant conflict as people struggle to break free from societal structures. Science involves a subjective or objective approach to research, necessitating a range of assumptions being made with regard to ontology, epistemology, human nature and methodology, a view supported by Porter (1996).

Ontology is the branch of Philosophy concerned with the nature of existence, with Burrell and Morgan (1979), stating it as being the very essence of a phenomenon that is under investigation. Maggs-Rapport (2001), concurs it is the real subject matter of the

research. The ontological context questions the nature of reality and the researcher must ascertain whether the reality is something that is external to the individual at one extreme or whether it is a creation of individual consciousness at the other, to underpin this Morgan and Smircich (1980) introduce the continuum of ontological assumptions, which differentiates between reality as a concrete structure and reality as a product of human imagination.

Epistemology relates to knowledge, and assumptions must be made about the way in which the world should be understood, and how this should be communicated to others as knowledge (Burrell & Morgan, 1979). On one hand, knowledge is seen as something that can be acquired by the individual, on the other extreme something that has to be personally experienced.

The phenomenological approach adopts ontology and epistemology which legitimates the value of individuals beliefs, focuses on a socially agreed understanding and attempts to makes sense of participants motives, actions and intentions in a way that is meaningful for them (Saunders et al, 2009).

### **3.3 Methodological Considerations**

#### **3.3.1 Justification for the Methodology**

The Author suggests that the study of Clinical Leadership is rooted firmly in the phenomenological paradigm and its underlying assumptions that social processes are created by individuals. To this end qualitative research methods are utilised in the form of semi-structured interviews and a focus group, an approach recommended by Morgan (1998), who suggests that pairing a complementary method with the principal method is good practice in any piece of organisational research. Both methods explore and gain an understanding of NHS Wirral's Provider Services current understanding of Clinical Leadership, therefore attempting to establish the potential influence of Clinical Leadership on the delivery of NHS Wirral's Provider Services.

The research uses qualitative data, obtained from a small number of respondents within the workplace, which potentially provides data that is rich and subjective (Collis & Hussey, 2003). Whilst predominantly inductive in nature due to the small size of the research and the qualitative nature of the data being collected, there is an element of deduction due to the utilisation of theoretical techniques in the development of the research instruments.

Use of a case study approach to the research methodology is deemed to be the most appropriate to explore and challenge existing theory and is widely recognised as a valid methodology (Easterby-Smith, Thorpe & Lowe, 2002; Saunders et al, 2009). This supports the researcher in gaining a rich understanding of the context of the research and the processes being enacted, therefore answering the “why” as well as the “what” and “how”. In addition this approach is suitable as the research is small scale and limited to a short time period.

### **3.3.2 Limitations of the Methodology**

A potential limitation to consider is the Department of Health (DH, 2010) announcement NHS Provider Services will need to reconsider their organisational format and look towards vertical integration with Acute Hospital Services by March 2011. This could challenge the validity of findings as potentially respondents may give less open and honest answers through fear of their positions. This may happen, for example when the subject wishes to give a preferred image rather than fact, known as social desirability bias, or when the subject gives answers, which they think, are expected and is known as evaluation apprehension (Bowling, 2002; Chung & Munroe, 2003). These views are supported by Hayes (2007) who advises that in time of change staff may change their personal views to reflect what they believe the Organisation may wish to hear. Whilst the Author acknowledges that this may potentially be viewed as a threat to the validity of the findings, every opportunity is taken to ensure anonymity of the respondents and reassurance is given of the integrity of the Author.

In addition the amount of time and resources available to the Author influenced the choice of research strategy and chosen research methods.

### **3.3.3 Validity, Reliability and Triangulation of the Data**

Triangulation was first used in the social sciences to characterise the use of multiple methods to measure a single construct and is an inductive or logical process (Yin, 2003). This view is shared by Johnstone (2004, p.264), who describes triangulation as the collection of data that whilst necessary, is insufficient on its own to ensure that phenomena are “*explained in a rigorous and credible manner*”.

There are two different types of methodological triangulation; within-method and across-method. Within-method triangulation is the simplest form and is used when the phenomenon being studied is multi-dimensional, for example, two or three different

qualitative instruments may be used to measure the same phenomenon. Across-method or between-method triangulation involves combining research strategies from two or more paradigms in the same study to try to achieve convergent validity in the analysis of a phenomenon.

In applying methodological triangulation Mitchell (1986, p.22-23) identifies four key principles:

*“(1) The research question must be clearly focused; (2) the strengths and weaknesses of each chosen method need to complement each other; (3) the methods need to be selected according to their relevance to the phenomenon being studied; and (4) the methodological approach needs to be monitored throughout the study to make sure the first three principles are followed”.*

In order to achieve triangulation in this study, the Author follows Mitchell’s (1986) framework. As this study is theoretically driven by the phenomenological paradigm the Author will use within-method triangulation between the two qualitative methods to support the validity and reliability of results obtained. In addition, all questions will be linked to the Conceptual Model to support the triangulation of data, a view that Coyle and Williams (2000) argue allows qualitative findings to provide salient data on subjective meanings and knowledge production.

Whilst Saunders et al (2009) suggest that the credibility of any research project is dependent entirely on the reliability and validity of its findings, and that the best a researcher can aim to achieve is to engage in robust research design in order to avoid getting things wrong, Lewin (2005, p.216) describes reliability as the *“stability or consistency of measurements”*. Easterby-Smith et al (2002) indicate that reliability can be assessed by either a deductive approach, which asks will the measure provide the same results if applied on different occasions, or the inductive approach, which asks if similar observations would be made by different researchers on different occasions.

When undertaking research Robson (2002) indicates that four threats to reliability need to be considered; subject error, subject bias, observer error and observer bias. Threats to reliability as a result of subject error or bias will be minimised by the guarantee of anonymity to participants in interviews and focus groups. The Author suggests that threats to reliability caused by observer error or bias will be minimised as all interaction will be undertaken by the Author in person.



Research validity may be defined as whether or not the data collected by the research answers the research questions posed (Lewin, 2005) and can be described as a measure of the truth or accuracy of a claim referring back to the propositions from which the study was developed. There are four types of validity; statistical, internal, construct and external validity.

Statistical validity relates to the relationships or differences drawn from statistical analysis and how accurately they reflect the real world. Internal validity is the extent to which the effects detected in the study are a true reflection of reality, rather than resulting from the effects of external variables. Construct validity is concerned with examining the fit between the conceptual definitions and methods of measurement and whether the method actually measures the concepts within the conceptual framework. Finally, external validity is concerned with the extent to which the study findings can be generalised beyond the sample population.

The Author suggests that methodological triangulation and ensuring the careful selection, design and piloting of research instruments, supports the achievement of internal and construct validity, with all methods utilised being piloted prior to use in the study in order to underpin validity and reliability. As part of the pilot phase questions and themes for the semi-structured interviews and focus group are completed by work colleagues of the Author who are not involved in the study, to ensure they are clear and lack ambiguity.

However, whilst similar results may be obtained if the study is repeated within a reasonable timescale, it is recognised that statistical validity cannot be successfully achieved as this would be difficult to assess due to the limited scope of the research. In addition, the Author cannot claim external validity for this study as it represents the views of a specific population at a specific point in time.

### **3.4 Research Design**

For the purpose of this study, the research design takes into account the research philosophy, principles and purpose and ensures that the research strategy chosen combines the best approaches to gaining the data required to answer the research question. The Author bases the research design on a case study approach incorporating a phenomenological view to gain sufficient quality and quantity of data.

The research methods chosen by the Author (semi-structured interviews, focus group) examine the major elements represented within the conceptual framework in order to underpin the achievement of the research aims.

Consideration is given to the accessibility of data against the chosen methods and the overcoming of organisational constraints so as to ensure completion of the dissertation within allocated timescales. Initial discussions took place in (August 2009) with the Director of Primary Care and Provider Services (NHS Wirral) to ensure that the subject of the dissertation was not seen as being sensitive or controversial and was unlikely to cause harm or embarrassment to the Organisation.

The target population for this study are Senior Management staff employed within NHS Wirral Provider Services. Two key groups of staff are included in the research, namely Chief Executive/Director level posts and Senior Heads of Clinical Services. Holloway and Wheeler (2002), identify that qualitative data collection requires different sampling techniques to those used in quantitative methods. They argue that the selected sample should be criterion based, that is the participants should have insight into the situation under study. It is for this reason that the Author includes these staff groups in this study, as they represent the top two tiers of leadership structure within NHS Wirral Provider Services and so provide the Author with the opportunity to develop an understanding of Clinical Leadership at all levels and therefore potentially provide a rich source for data collection.

The Chief Executive and each of the five Director level posts will be asked to participate in a semi-structured interview. Each of the ten clinical services has a Head of Service who is an experienced qualified manager (mixture of clinical/non-clinical posts) who is responsible for the day to day management of the clinical divisions. These Heads of Services will be invited to participate in the focus group session.

### **3.4.1 Semi Structured Interviews**

It is suggested (Green & Thorogood, 2004) that the semi-structured interview, is the most common method of qualitative research currently in use and involves verbal communication between the researcher and the subject, during the course of which information is provided to the researcher. Interviews can vary in style from a totally unstructured interview, in which the content is completely controlled by the subject, to tightly structured interviews in which the content is similar to that of a questionnaire.

Brown (1998) proposes that semi-structured interviews are far more likely to be successful than more tightly controlled methods when encouraging people to disclose information.

Semi-structured interviews allow the researcher to explore greater depth of meaning than is possible with other methods of data collection. The data obtained from qualitative interviews can be used to increase our insight into social phenomena rather than assume representativeness; however, this limits the generalisability of results.

While semi-structured interviews are designed to include strategies that allow the researcher increasing amounts of control which can be achieved by designing questions prior to the interview and specifying the order in which they are asked (Saunders et al, 2009), they also allow a degree of flexibility for the researcher, as explanation or modification of the question can take place to allow clarity between researcher and subject. The questions used may vary from interview to interview, depending on progress in each individual setting. As a result of this in built flexibility, the opportunity to explore some responses in detail will arise during the course of the interview, providing depth and meaning to the data, and underpinning the phenomenological approach.

When compared to questionnaires, interviews have a higher response rate, which ensures that the sample is representative, and they facilitate the collection of data from subjects who may be unlikely to complete questionnaires. It is for these reasons that the Author has adopted the approach of semi-structured interviews to allow clear communication that is meaningful to both researcher and subject and which will maintain the integrity of the data collected.

The themes and questions prepared by the Author are developed from the literature review relating to Leadership and Clinical Leadership and can be linked to the conceptual model. References are used to enable the Author to ensure the question's validity and relevance to the conceptual model.

## **1. Leadership Theory**

- a) Can you describe what Leadership is?** [This question has been constructed to consider the difference between Leadership and Clinical Leadership (Kotter, 1990; Edmonstone & Western, 2002)]

- b) Can you describe what Clinical Leadership is?** [This question has been constructed to clarify what constitutes leadership in a clinical setting (Edmonstone & Western, 2002)].

## **2. Leadership Qualities**

- a) Can you describe what traits Leaders exhibit?** [This question has been constructed to consider influence of leadership theory and traits approach to leadership (Jung, 1923; Stodgill, 1974; Hogan, 1991; Hughes et al, 2009)].
- b) What do you think are the main attributes exhibited by Clinical Leaders?** [This question has been constructed to consider if there are attributes that Clinical Leaders exhibit (Cook & Leathard, 2004; Leadership Qualities Framework, 2006)].
- c) What qualities do you think effective Clinical Leaders possess?** [This question has been constructed to consider what qualities make Clinical Leaders effective (Cook & Leathard, 2004; Alimo-Metcalfe & Alban-Metcalfe, 2006; Leadership Qualities Framework, 2006)].

## **3. Benefits of Clinical Leadership**

- a) What benefits do you believe Clinical Leadership can bring to the Individual?**
- b) What benefits do you believe Clinical Leadership can bring to the Service/Team?**
- c) What benefits do you believe Clinical Leadership can bring to the Organisation?** [These questions have been constructed to consider the benefits of Clinical Leadership to the two levels of the organisation involved in this research and consider the work of Porter (1980), Daft (2008), Jasper & Jumaa (2005) and Adair (2004)].

## **4. Learning and Development**

- a) What leadership development and training have you received?** [This question has been constructed to consider what personal development leaders have received and consider its impact on leadership development (Hewison & Griffiths, 2004; Cook & Leathard, 2004; Jasper and Jumaa, 2005)].

- b) Can you describe your learning style?** [This question has been constructed to consider learning styles and work of Kolb (1983) and Jasper & Jumaa (2005) who suggest that effective Clinical Leaders learn more from their experiences].

## **5. Culture**

- a) From your own experience how do you believe the current workforce perceives Clinical Leadership?** [This question has been constructed to consider the theory of organisational culture and its impact on Clinical Leadership (Schein, 2004; Scott & Caress, 2005)].

### **3.4.2 Focus Groups**

Krueger and Casey (2009, p.10-11) suggest that “*The focus group interview taps into human tendencies. Attitudes and perceptions relating to concepts, products, services or programs are developed in part by interaction with other people. We are a product of our environment and are influenced by people around us*”. Bowling (2002), describes focus groups as unstructured interviews that take place within a small interactive group, thus indicating that their major advantage is the stimulation of in-depth discussion prompted by group dynamics, assisting participants to understand their social world. Kitzinger (1995) concurs that the use of focus groups to explore what people think, how they think and why they think in a particular way is useful to gain insight into their understandings and priorities.

Many believe (Krueger & Casey, 2009; Bowling 2002) that interaction is the key to the success of this method as it gives a high level of face validity. This is predominantly because what participants say can be confirmed, reinforced or contradicted within the group discussion, which is in contrast to interviews where this is not so attainable. It can therefore be argued that this mirrors the philosophical underpinning of the interpretive phenomenologist’s paradigm and it is for this reason that the Author suggests that this method is compatible with this research study.

Through the use of focus groups people are encouraged to talk to one another, to ask questions, to share anecdotes and to comment on each other’s experiences and points of view (Kitzinger, 1994). In addition, one of the major benefits is that as a result of group processes, participants are often willing to discuss their feelings and beliefs in more depth than in a one to one interview (Kitzinger, 1996). Hughes and Dumont (1993) expand this further and suggest that by gaining access to such interpersonal

communication, and analysis of the humour, consensus, dissent and different types of narrative used within the group, the researcher can identify shared and common knowledge which can help highlight sub cultural values or group norms. Watts and Ebbutt (1987) suggest that focus group participants are more willing to be critical, due chiefly to the feeling of mutual support within the group, a view supported by Kitzinger (1995) who indicates that the atmosphere of mutual support facilitates the expression of deep rooted feelings that may be common to the participants subculture but which they assume may be deviant.

There are many documented advantages to focus groups, with Morgan (1998) identifying that they provide information on the dynamics of attitudes and opinions in the context of the interaction that occurs between participants, in contrast to the rather static way in which these phenomena are portrayed in questionnaire studies. This view is shared by Butler (1996) who suggests that focus groups may encourage a greater degree of spontaneity in the expression of views than alternative methods of data collection. Peters (1993) further suggests that focus group participants may feel supported and empowered by this sense of group membership and cohesiveness.

However, Henderson (1995) identifies that certain members of the group may be more assertive or articulate than others and their views may come to dominate the session. In order to influence the interaction that takes place within the group, the behaviour of the moderator and the verbal and non-verbal cues given to the group are of vital importance (Vaughn, Schumm & Sinagub, 1996). For the purpose of this research the Author will strike a balance in terms of prominence and involvement with the group, generating, but not dominating, the discussion and ensuring that overall input from the moderator will constitute no more than 8% of the resultant transcript. This is in line with the recommendation of Hague (1993) who identifies that moderator involvement should only range from 5% - 10%.

The use of focus groups is not without its critics with some arguing (McMillan & Weyers, 2010) that there is little evidence to indicate that focus groups are superior to individual interviews of equivalent numbers in terms of the number or quality of ideas which are generated, whilst Krueger and Casey (2009) indicate that members may modify their statements as the group progresses. Carey and Smith (1994) discuss this and suggest that it is essential that the researcher is able to assess the extent in which responses may have been altered due to peer pressure or coercion, whilst Saunders et al

(2009) argue that as these processes are replicated in reality, the very fact that they occur can provide the researcher with valuable insights.

Recruiting to focus groups can be problematic as difficulties can be experienced when the topic is sensitive, when payment of participants is an issue, when people fail to attend or when access is withheld (MacDougall & Fudge, 2001). In order to overcome these potential problems, the Author will send personalised invitations as suggested by MacDougall & Fudge (2001), reinforcing the fact that each participant has a unique contribution to make which will add value to the findings.

Many have determined (Kreuger & Casey, 2009; Saunders et al, 2009) that eight to twelve participants are the ideal for a focus group. As previously discussed the focus group consists of ten Heads of Clinical Services, suggested by Kreuger and Casey (2009) to be a suitable number of participants. Indeed this method is chosen specifically as the numbers involved allow a complete involvement of this tier of staff in the research.

The focus group is developed around the conceptual model and debate focuses around the key areas as a means of covering the main themes identified in the literature review. References are included to enable the Author to ensure the validity and relevance of the questions to the conceptual model.

## **1. Leadership Theory**

- a) Can you describe what Leadership is?** [This question has been constructed to consider the difference between Leadership and Clinical Leadership (Kotter, 1990; Edmonstone & Western, 2002)].
- b) Can you describe what Clinical Leadership is?** [This question has been constructed to clarify what constitutes leadership in a clinical setting (Edmonstone & Western, 2002)].

## **2. Clinical Leadership Qualities**

- a) What do you think are the main attributes exhibited by Clinical Leaders?** [This question has been constructed to consider if there are attributes that Clinical Leaders exhibit (Cook & Leathard, 2004; Leadership Qualities Framework, 2006)].

- b) What qualities do you think effective Clinical Leaders possess?** [This question has been constructed to consider what qualities make Clinical Leaders effective (Cook & Leathard, 2004; Alimo-Metcalfe & Alban-Metcalfe, 2006; Leadership Qualities Framework, 2006)].

### **3. Benefits of Clinical Leadership**

- a) What benefits can Clinical Leadership bring to the Individual, Service/Team and Organisation?** [These questions have been constructed to consider the benefits of Clinical Leadership to all three levels of the organisation and consider the work of Porter (1980), Daft (2008), Jasper & Jumaa (2005) and Adair (2004)].

### **4. Learning and Development**

- a) What leadership development and training is available to you?** [This question has been constructed to consider what personal development leaders have received and consider its impact on leadership development (Hewison & Griffiths, 2004; Cook & Leathard, 2004; Jasper and Jumaa, 2005)].
- b) What are your learning styles?** [This question has been constructed to consider learning styles and work of Kolb (1983) and Jasper & Jumaa (2005) who suggest that effective Clinical Leaders learn more from their experiences].

### **5. Culture**

- a) From your own experience how do you believe the Organisation perceives Clinical Leadership?** [This question has been constructed to consider the theory of organisational culture and its impact on Clinical Leadership (Schein, 2004; Scott & Caress, 2005)].

### **3.5 Research Procedures**

#### **3.5.1 Semi-Structured Interviews**

The interview questions are to be initially piloted with three colleagues to ensure the questions are clear, logical and no ambiguity is present. The selected interviewees are sent a letter in advance of the interview (Appendix One), explaining the purpose of the



research and general content of the questions (McMillan & Weyers, 2010). Mutually convenient dates, times and locations for the interviews are agreed with the interviewee and Author.

Following standard interview technique (McMillan & Weyers, 2010) from the start of the interview the Author explains the purpose of the research, how data will be used (including access), anonymity and time limit for the interview. In addition it is made clear to the interviewee that at any time they can terminate the interview and can decline to answer a question. Care is taken to ensure that where possible all questions are posed in the same way.

Interviews are undertaken in a neutral environment, with no telephone access to disturb the proceedings and are recorded using a digital voice recorder and transcribed as soon as possible after the interviews. This method of recording is popular and as Collis & Hussey (2003) highlight can avoid the automatic screening and summarising of information by the researcher. All tapes are destroyed on completion of the research.

The interview transcripts are analysed and coded to cover relevant issues and encompass the findings of the literature review. In addition appropriate and relevant quotes are noted for inclusion within Chapter Four – Research Findings which can increase the validity of the research (Jankowicz, 2005). Appendix Two shows the questions and structure of the interviews.

### **3.5.2 Focus Group**

All respondents are sent a personalised invitation letter to the focus group (Appendix Three) explaining the purpose of the research and asking them to confirm attendance in advance of the meeting to ensure sufficient refreshments and seating.

From the start of the session the Author explains the purpose of the research, how data will be used (including access), anonymity and time limit for the session. The Author asks for all participants' cooperation with regard to respecting individual's opinions, allowing them to speak freely and ensuring that everyone's dignity and respect is maintained throughout the session.

The discussion is led by the Author who uses pre-prepared questions as recommended by Bowling (2002). The content of which (Appendix Four) are based on elements of

the conceptual model and debate focuses around the key areas as a means of encapsulating the themes identified in the literature review.

The session is conducted in a neutral environment, with no telephone access to disturb the proceedings and is recorded using a digital voice recorder and transcribed as soon after the session as possible. In addition after each question a summary of the points raised by all is clarified by the Author and captured on additional notes by the Author's administrative assistant. All tapes are destroyed on completion of the research.

Analysis and coding of the focus group transcripts occurs to cover relevant issues and encompass the findings of the literature review. In addition appropriate and relevant quotes are noted for inclusion within Chapter Four – Research Findings which can increase the validity of the research (Jankowicz, 2005).

### **3.6 Ethical Considerations**

A number of ethical considerations are reviewed during the construction of the methodology (Saunders et al, 2009) including confidentiality and privacy, as often information obtained through research is judgemental, value-laden and politically sensitive (Jankowicz, 2005). The impact of the research is considered as is the possibility that the findings might be seen as positive or negative towards the Organisation. In view of this the dissertation proposal has been submitted to NHS Wirral's Research and Governance Committee for approval before commencement of the research (Appendix Five).

Anonymity and confidentiality are of paramount importance when undertaking this type of research (Saunders et al, 2009) and when reporting the findings. All respondents are given the option not to participate in the research and to refrain from answering questions during the semi structured interviews. In addition, the Author obtains written permission of respondents to quote directly from the semi-structured interviews and focus group.

The Author is confident that the research is undertaken with integrity and in the best interests of the Organisation.

### **3.7 Summary**

This chapter introduces the phenomenological research philosophy which defines the research methodology and provides justification for the research design and use of semi structured interviews and focus group. Construction of the research questions against the conceptual model and key findings of the literature review is demonstrated. In addition, issues of reliability, validity and triangulation of data along with limitations of the methodology and ethical considerations are addressed.

## **4.0 Chapter Four – Findings**

### **4.1 Introduction**

In this chapter, the Author discusses and analyses the research findings of the semi-structured interviews and focus group described within Chapter Three. Interpretation and discussion of the findings within the context of the literature outlined in Chapter Two are addressed in Chapter Five.

The Author acknowledges that qualitative data is non-standardised and based on individual's experiences of events, processes and systems (McMillan & Weyers, 2010) and therefore any analysis is conducted utilising conceptualisation, as there is no standardised approach to the analysis of qualitative data. Saunders et al (2009), suggest that when analysing qualitative data, the researcher looks to identify key emerging themes and relationships. Therefore, in order to accurately reflect the relationship between the findings and the literature, the Author presents the results by elements of the conceptual framework introduced in Chapter Two and looks to identify common themes which will be presented in Chapter Five. Selected data is illustrated using relevant charts and text and where appropriate direct quotes are included to enrich and expand on the data.

### **4.2 Application of the Methodology**

#### **4.2.1 Response Rates**

All five Directors and Chief Executive contacted to participate in the semi-structured interviews agreed to be interviewed and all six interviewees answered every question within the semi-structured interview. All ten Heads of Clinical Services invited to attend the focus group attended and actively participated. The response rate is good and therefore the research proceeds on the basis that the study is a representative, unbiased research project.

#### **4.2.2 Characteristics of Respondents**

All six interviewees participating in the semi-structured interviews have many years experience within the NHS and are in Director level positions, with one interviewee being the Chief Executive of NHS Wirral. Of the six interviewees, three have clinical qualifications and three have non-clinical qualifications. Chart 4.1 shows the qualifications of the interviewees.

**Chart 4.1: Qualifications of Semi-Structured Interviewees**

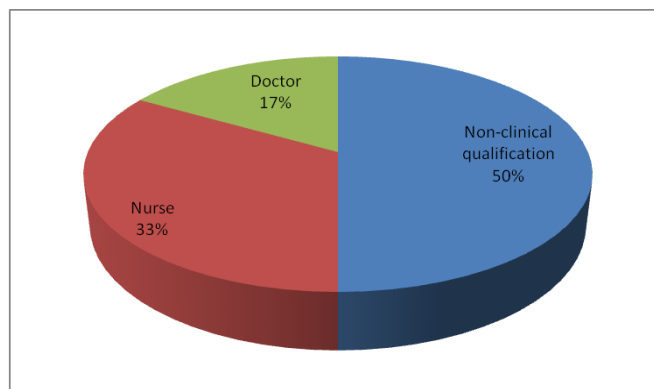
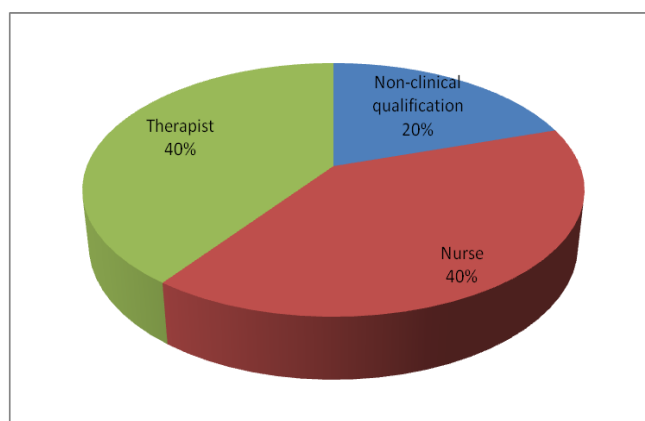


Chart 4.2 shows the qualifications of the focus group participants. Of the ten participants, eight have clinical qualifications and two have non-clinical qualifications. All ten of the participants in the focus group are Heads of Clinical Services and all have a range of experience within NHS Wirral Provider Services and are therefore representative of this tier of management as a whole.

**Chart 4.2: Qualifications of Focus Group Participants**



## **4.3 Findings from the Semi-Structured Interviews**

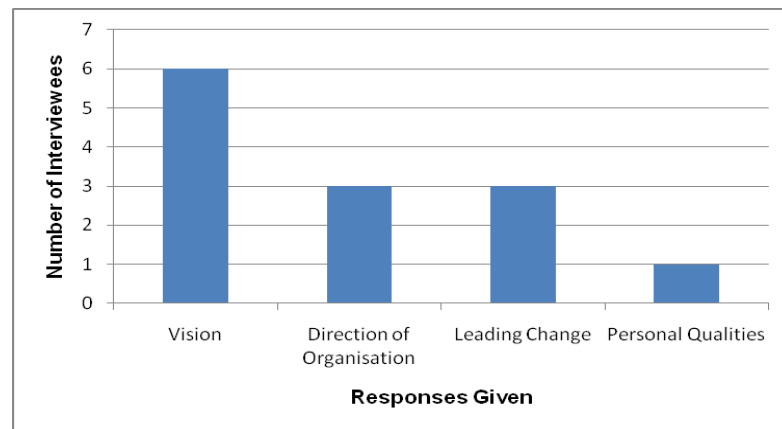
### **4.3.1 Leadership Theory**

This element is investigated using the semi-structured interview, with Question 1(a) asking “*Can you describe what leadership is?*”

All six interviewees include “*Having a vision*” within their responses, with three interviewees expanding on this further to include “*Deciding on the direction of travel for the Organisation*” and “*Knowing where the Organisation should go*”. Three interviewees believe “*Leading change*” is a key feature of leadership, with one interviewee describing leadership “*As a collection of skills and personal qualities that*

*assists the achievement of Organisational goals*” a view supported within the literature by Hughes et al (2009). Chart 4.3 presents this information diagrammatically.

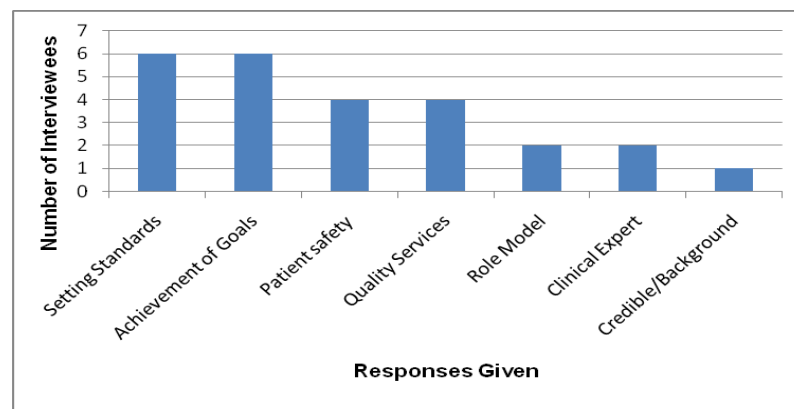
**Chart 4.3: Question 1(a) “Can you describe what leadership is?”**



Question 1(b) directly relates to the interviewees views on Clinical Leadership and asks “Can you describe what Clinical Leadership is?”

All six interviewees state that Clinical Leadership is the “*Setting of standards*” and “*Achievement of Clinical Goals*” with four interviewees believing that Clinical Leadership underpins “*Patient Safety*” and delivery of “*Quality Services*” a view supported by Millward and Bryan (2005). Two interviewees describe Clinical Leadership as being “*A role model*” and “*Clinical expert*” with one interviewee expanding upon this to define “*Clinical Leadership is being clinically credible, but not necessarily being from the clinical background that you represent*”. Chart 4.4 presents this information diagrammatically.

**Chart 4.4: Question 1(b) “Can you describe what Clinical Leadership is?”**



### 4.3.2 Leadership Qualities

This element is investigated using the semi-structured interview Questions 2(a), 2(b) and 2(c) with Question 2(a) directly asking the interviewees *“Can you describe what traits Leaders exhibit?”*

All six interviewees comment that traits possessed by leaders are *“Initiative”*, *“Self-Belief”* and *“Personality type”*, with two interviewees also highlighting *“Empathy”* and *“Personal Integrity”*.

Question 2(b) relates to the attributes of Clinical Leadership and asks *“What do you think are the main attributes exhibited by Clinical Leaders?”*

All six interviewees state that a *“Clinical background”* or *“Clinical qualification”* is relevant; with four interviewees expanding their answers to suggest that this should not be profession based and does not necessarily mean that a clinical qualification is required, with one interviewee suggesting *“You shouldn’t have to be a Nurse to lead Nurses, its (Clinical Leadership) more about having the right skills and qualities”*.

Question 2(c) asks *“What qualities do you think effective Clinical Leaders possess?”*

Three interviewees highlight *“Creativity”* as being a quality that effective Clinical Leaders possess, with two respondents believing *“Passion to improve patient care”* to be relevant. Two interviewees discuss ability to influence change as being an important attribute with one interviewee stating *“They (Clinical Leaders) lead change, not manage it”*.

### 4.3.3 Benefits of Clinical Leadership

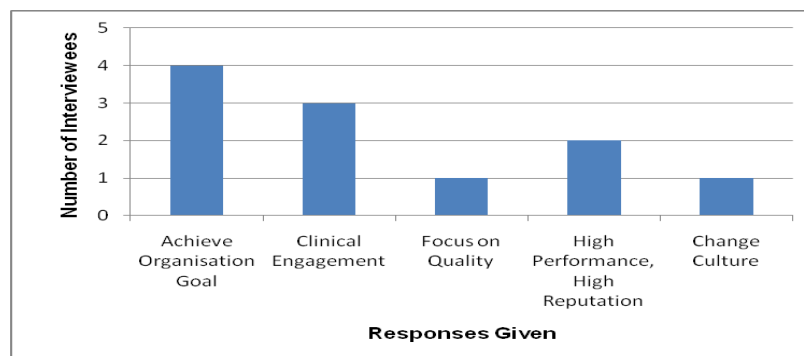
This element is investigated using the semi-structured interview Questions 3a, 3b and 3c and all directly relate to the potential benefits of Clinical Leadership. Questions 3a, 3b and 3c ask *“What benefits do you believe Clinical Leadership can bring to the: Individual (3a); Service/Team (3b); Organisation (3c)?”*

Regarding the benefits of Clinical Leadership to the individual (Question: 3a) all six interviewee’s responses are limited to *“Improve patient care”* or *“Improve clinical services”*, with no expansion given by any of the interviewees in response to this question.

In terms of the benefits of Clinical Leadership to the service/team (Question: 3b) all six interviewees' state *"Improve the delivery of clinical services"* with two interviewees adding *"Brings focus to the team"*.

Responses regarding the benefit of Clinical Leadership to the Organisation (Question: 3c) were more detailed. Four interviewees highlight the *"Achievement of Organisational goals"* as a benefit of Clinical Leadership. Three interviewees state that Clinical Leadership can support the *"Development of Clinical Engagement"* in an Organisation with one interviewee developing this further to include *"Ensures Organisation is focussed on clinical quality and not just targets and money"*. Two respondents add that a potential benefit of Clinical Leadership to an Organisation is that it supports the Organisation *"To become a high performance, high reputation Organisation"* with one respondent expanding on this response to include *"Brings about change in Organisational culture"*. Chart 4.5 presents this information diagrammatically.

**Chart 4.5: Question 3(c) *"What benefits do you believe Clinical Leadership can bring to the Organisation?"***



#### 4.3.4 Learning and Development

This element is investigated using the semi-structured interview Question 4a and 4b. Question 4 (a) examines the interviewees learning and development in relation to leadership by asking *"What leadership development and training have you received?"*

Of the six interviewees, five had undergone Leadership Qualities Framework (Institute for Innovation & Improvement, 2006) assessments within the preceding three years, with four having been assessed individually and collectively as a Directors group within the last two years. Two interviewees have previously attended an *"Aspiring Directors Course"* which is facilitated by the North West Strategic Health Authority. One

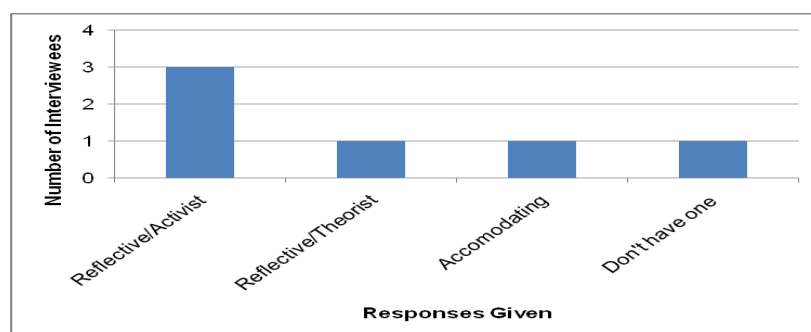


interviewee has an MBA qualification with two respondents highlighting *“I have no formal qualifications, it is all on the job learning”* as being an element of the leadership development they have received.

Question 4 (b) asks the interviewees to describe their learning style by asking *“Can you describe your learning style?”*

Three interviewees assert that they have a reflective/activist learning style, with one interviewee stating they have a theorist/reflective learning style. One interviewee believes they have an *“Accommodating learning style”* which they view as *“Relying on intuition rather than logic. People with this style prefer to work in teams”*. However, one interviewee claims not to *“Have a learning style, I just get on with it – definitely not reflective”* and further expands their answer to state *“I had a coach once it was uncomfortable for me as I really don’t like analysing what I have done”*. Chart 4.6 presents this information diagrammatically.

**Chart 4.6: Question 4(b) “Can you describe your learning style?”**



#### 4.3.5 Culture

This element is investigated using the semi-structured interview Question 5 and investigates the current Organisational culture regarding Clinical Leadership. Question 5 asks the interviewees *“From your own experience how do you believe the current workforce perceives Clinical Leadership?”*

Of the six interviewees, two discuss that Clinical Leadership is perceived as being *“Credible and high profile”* and also highlight the Author’s post as Clinical Director as *“Being important in raising the profile of Clinical Leadership with frontline staff”*. However three interviewees suggest that current workforce perception is *“Mixed”* with one interviewee expanding their response to include *“I am not sure that they (clinicians) really know what it (Clinical Leadership) is”*. One interviewee claims that

they are not aware of what the current workforce perception is regarding Clinical Leadership.

#### **4.4 Findings from the Focus Group**

##### **4.4.1 Leadership Theory**

Responses within the focus group to Question 1(a) “*Can you describe what leadership is?*” concur with the semi-structured interviews with “*Vision*”, “*Achievement of Goals*” and “*Leading change*” highlighted as key features of leadership. As a group the participants believe “*Leadership is a skill that you either have or don’t have*” with a common theme developing that “*Only certain people within this Organisation have these skills and are good leaders*”. When probed further regarding the qualities these identified individuals may possess, the focus group participants refuse to elaborate as they believe their comments may easily identify individuals. This statement supports the view of Hayes (2007), who advises that when questioned on areas that they perceive to be organisationally sensitive staff responses may be modified.

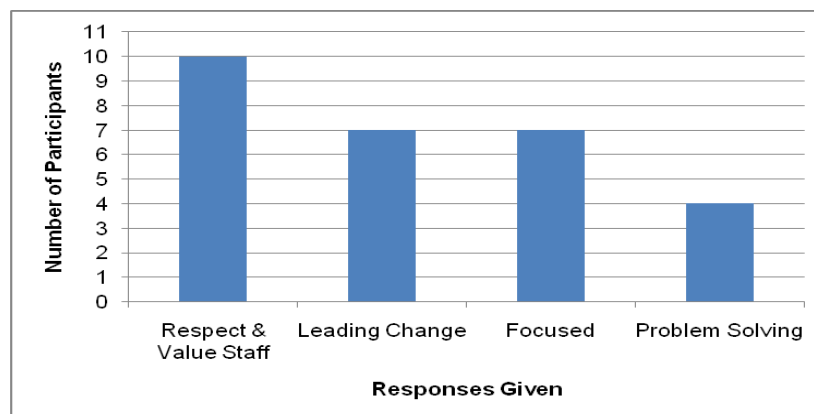
The focus group views relating to Question 1(b) “*Can you describe what Clinical Leadership is?*” are limited and include “*Delivery of high quality services*” and “*Good patient care*”, with only one participant expanding their view to include “*Clinical champion, role model*”. In order to gain more insight into the views the Author asks “*Do you need to be from the clinical background that you represent?*” a theme highlighted within the semi-structured interviews as not being essential. In contrast to the semi-structured interviews the majority of the focus group believes that “*If you are to clinically lead staff then you should be from that clinical background*”. However the two participants of the focus group who are not from clinical backgrounds state “*I find that not having a clinical background means I challenge my staff more and that this gets results. Also I believe they (staff) respect me more as I am not from the same background as them*” with one respondent challenging the group by asking “*Are you saying I can’t be a good leader if I am not a clinician?*” This led to some debate within the group, with the subsequent view expressed by five of the participants being modified to suggest that “*It (Clinical Leadership) is perhaps more about the skills of the person and where they have worked*”, “*They (named non-clinical Head of Service) are a good leader and I think they are right perhaps you don’t need to be from a clinical background*”. This modifying or changing of views as the group progresses is a common feature of focus groups (Krueger & Casey, 2009).

#### 4.4.2 Leadership Qualities

Responses within the focus group to Question 2(a) *“What do you think are the main attributes exhibited by Clinical Leaders?”* concur with the semi-structured interviews with *“Clinical qualification”*, being highlighted and expanded to include *“Clinical experience”*. The focus group discussed this question in detail and further stated that *“Integrity”*, *“Reliability”* and *“Commitment to staff and patients”* as being attributes of Clinical Leaders.

This discussion led onto Question 2(b) *“What qualities do you think effective leaders possess”* with all of the participants agreeing that *“respect and value for staff”* are evident in effective Clinical Leaders. Seven participants state that *“Focus”* and *“Problem solving”* are key qualities and four participants suggest that *“Leading change”* is evident in an effective leader which concurs with the response from the semi-structured interviews. This information is shown diagrammatically in Chart 4.7.

**Chart 4.7: Question 3(c) *“What qualities do you think effective leaders possess?”***



#### 4.4.3 Benefits of Clinical Leadership

When asked Question 3(a); *“What benefits can Clinical Leadership bring to the Individual, Service/Team and Organisation?”*, regarding the benefits of Clinical Leadership to the individual the group collectively state *“Improvements in patient care”* as a major benefit, however when asked if the benefit was to the patient rather than the individual staff member the group strongly state that Clinical Leadership would improve patient care *“As it is frontline staff who care for patients”*. The Author was unable to ascertain any further responses from the focus group to this question.

In terms of the benefits of Clinical Leadership to the service/team the focus group’s responses mirror those of the semi-structured interviews with *“Improve the delivery of*

*clinical services*” being cited as the major benefit of Clinical Leadership to a service/team. In addition the focus group developed their responses to include *“Increased efficiencies in services”* and when asked to expand upon what efficiencies would occur several respondents raised financial efficiencies as being a benefit with one respondent suggesting *“It can make us more attractive to potential buyers such as GPs if we are efficient and cost effective”* a view supported by Porter (1980) in the achievement of competitive advantage.

Responses regarding the benefit of Clinical Leadership to the Organisation reflect those from the semi-structured interviews, with the *“Achievement of Organisational goals”* being perceived by the focus group as a major benefit to the Organisation. In addition the focus group included *“Financial efficiencies”* as a potential benefit and discussed at length the current financial climate within the Organisation and wider NHS.

#### **4.4.4 Learning and Development**

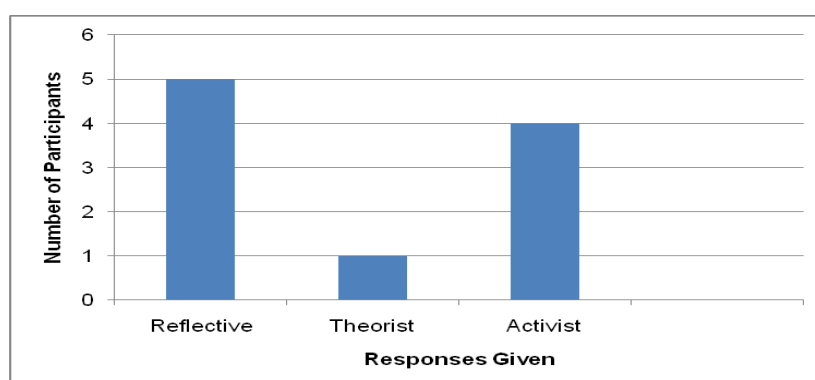
This element is investigated using Questions 4a and 4b. Question 4 (a) examines the focus group participants learning and development in relation to leadership by asking *“What leadership development and training have you received?”*

All participants say that they have attended in house management training *“People Management”* which appears to be predominantly management focused and does not contain leadership development. This response from the focus group concurs with Kotter (1990) who highlights the difficulty between manager and leader development. Participants also highlight that they are subject to six-monthly appraisals from their Line Manager although it is unclear as to what element of leadership development this provides and when asked the participants are unable to expand upon their answers. When asked by the Author what specific leadership development they had received six participants state they have attended *“Leadership modules”* provided at local Universities via the Strategic Health Authority’s learning and development programme, although these modules appear only to be available to those participants who are registered nurses. When other participants from non-nursing backgrounds were asked if they could access these modules they responded strongly *“You only get this if you are a Nurse ... they (Nurses) get all the learning and development”* with one participant expanding this further to include *“The NHS is not just Doctors and Nurses, but people forget about the rest of us (Therapists)”*.

Question 4 (b) examines the participants learning style by asking “*Can you describe your learning style?*”

Five participants assert that they have a reflective learning style, one participant states they have a theorist learning style and four believe they have a predominantly activist learning style. These responses are similar to those given within the semi-structured interviews. One respondent with a reflective learning style expands their answer to include “*I would say I follow the Kolb Learning cycle in that I plan, do, review and conclude in that order*”. Chart 4.8 presents this information diagrammatically.

**Chart 4.8: Question 4(b) “*Can you describe your learning style?*”**



#### 4.4.5 Culture

Question 5 “*From your own experience how do you believe the current workforce perceives Clinical Leadership?*” investigates the current Organisational culture in relation to Clinical Leadership.

Responses to this question are variable from the focus group with no one dominant theme or view expressed. There is a general belief from the participants that Clinical Leadership is recognised within the Organisation but that this could be enhanced to include frontline staff, as the participants were unsure whether frontline staff would be aware of what Clinical Leadership is. One participant highlights that “*Job descriptions, appraisals and knowledge/skills frameworks all acknowledge Clinical Leadership*” but that often this is not translated effectively to the frontline workforce. An additional theme to be articulated was that the achievement of organisational goals often “*Takes precedent over the opinions of Clinical Leaders*”. When asked by the Author to expand upon this response the participant highlights an incident where they had been asked by a Director to implement a service change but the service’s Clinical Lead had advised against it, however the Director had insisted on the service change. When asked if the

service change had been successful the participant states it had and that they had thought on reflection that the service's Clinical Lead was “ *Not a Clinical Leader*” but that the Director had shown themselves to be “*A Leader, although they are not a Clinician*”.

#### **4.5 Summary**

This chapter presents summarised and highlighted results from the semi-structured interviews and the focus group, across the key areas identified within the conceptual model. These findings will now be examined in the context of the literature review and key conclusions drawn.

## **5.0 Chapter Five – Conclusions and Implications**

### **5.1 Introduction**

In this chapter, the Author discusses how the findings outlined in Chapter Four contribute to the body of knowledge regarding Clinical Leadership as described in Chapter Two. This will answer the research question and satisfy the research aims.

The chapter begins with a critical evaluation of the adopted methodology then draws conclusions about the research aims in combination with the conceptual model. Finally, this chapter assesses the limitations of the research, its findings and proposes ways in which future research might further the understanding of Clinical Leadership and its influence on the delivery of NHS Wirral's Provider Services.

### **5.2 Critical Evaluation of Adopted Methodology**

Adoption of the phenomenological paradigm is appropriate to the research question as it allows the validity of organisations to be questioned in the real sense, thus supporting the research in examining staff perceptions of Clinical Leadership and its influence on the delivery of NHS Wirral's Provider Services.

The use of a combination of inductive and deductive methods allows the Author to employ existing theoretical frameworks to develop the research instruments. The research methods chosen by the Author (semi-structured interviews and focus group) examine the major elements represented within the conceptual model (Figure 2.5) in order to underpin the achievement of the research aims.

In terms of enabling a detailed examination of Clinical Leadership, the semi-structured interviews and focus group are predominantly successful and provide triangulated data which offer an in-depth insight into the research question. The use of deliberately open-ended questions means that at times interviewees and participants introduce new points which have not previously been considered and support a deeper understanding of Clinical Leadership and its potential influence on the delivery of NHS Wirral's Provider Services.

The Author finds that the research instruments are flawed to some extent as whilst the use of semi-structured interviews is deemed suitable to explore in greater depth the views of individuals and encourages open and honest responses, the Author finds that this encourages interviewees to progress the interview in different directions and often

to subjects unrelated to the research question. In addition, the Author's lack of experience in interviewing for research purposes and the unusual situation of interviewing Directors and the Chief Executive, means that the Author on occasion is unable to refocus the interviews to gain more in-depth answers, this is predominantly due to the Author's lack of confidence in managing the interviews and tackling the interviewees due to their organisational position.

A similar issue is experienced with the focus group, as whilst it is a suitable methodology to explore what, how and why people think in a particular way and therefore useful to gain insight into the understandings and priorities of participants, the Author finds that participants often move onto other subject areas unrelated to the research and at times participants are argumentative and defensive with each other. On reflection, the Author suggests that this may be as a result of participants experiencing pressure due to current organisational demands placed on them, as this is a theme raised throughout the focus group.

As discussed in Chapter Three, the Author acknowledges that social desirability bias may be introduced which can challenge the validity of the findings. The Author finds that respondents on occasion make reference to giving less open and honest answers through fear of their positions and the perception of what the Organisation may do. A view which Krueger and Casey (2009) and Hayes (2007), suggest is a common occurrence in focus groups and is often present during organisational change. The Department of Health (DH, 2010) announcement relating to NHS Provider Services and potential vertical integration with Acute Hospital Trusts was released five days prior to the focus group and the Author therefore acknowledges that this may have altered the views of the focus group in relation to the honesty of their answers. Whilst the Author at every opportunity reassures participants of their anonymity and the integrity of the Author, it is apparent to the Author that this does not alleviate the participants concerns.

On reflection, the Author suggests that the use of an anonymous questionnaire may support participants in providing less guarded responses and still provide robust data for analysis in support of the research question.

In conclusion, despite the issues discussed above, the methodology is suitably robust to provide reliable, meaningful and insightful data which meets the research aims.



### **5.3 Conclusions About the Research Aims**

In order to answer the research question set out in Chapter One: “*Clinicians in Leadership: To what extent does Clinical Leadership influence the delivery of NHS Wirral’s Provider Services?*”, the following three aims will be considered in relation to the findings within Chapter Four and literature within Chapter Two, so as to draw justified conclusions that answer each aim. The aims to be considered are:

- To critically review contemporary thinking on Leadership and Clinical Leadership
- To investigate NHS Wirral’s Provider Services current understanding of Clinical Leadership
- Compare and contrast the above two aims to determine the influence of Clinical Leadership on the delivery of NHS Wirral’s Provider Services

#### **5.3.1 Aim One: To Critically Review Contemporary Thinking on Leadership and Clinical Leadership**

The critical review of literature relating to Leadership and Clinical Leadership within Chapter Two highlights a number of salient points to consider which form the basis of the conceptual model (Figure 2.5).

Firstly, a number of leadership theories emphasise personal qualities (Jung, 1923; Stodghill, 1974; Hogan, 1991; Charan, 2007), the situation (Fiedler, 1967) and interaction with other people (Hollander, 1978; Hersey & Blanchard, 2001; Hughes, 2009) as being critical when defining leadership and what makes a leader effective. In addition, the literature available clearly defines leadership as a skill of understanding situations and influencing others to accomplish group goals (Hughes et al, 2009; Northouse, 2007).

Secondly, the concept of Clinical Leadership is still relatively new within the NHS. Many recent publications (DH, 2005, 2006, 2007, 2009a) articulate that Clinical Leadership is the key to successful change in the delivery of healthcare, assisting in modifying or transforming healthcare organisations and is crucial to the development of strategy, achievement of objectives and competitive advantage.

Thirdly, the NHS Leadership Qualities Framework (Institute for Innovation and Improvement, 2006) describes the qualities expected of clinical leaders and clearly incorporates the key leadership theories relating to characteristics (Jung, 1923; Hogan, 1991; Charan, 2007) and the work of Cook and Leathard (2004).

Finally, whilst it is evident (Kolb, 1983; Jasper & Jumaa, 2005), that effective Clinical Leaders prefer a more reflective learning style which encourages them to learn from experience, in order to transform and modernise services within the NHS a receptive and positive culture must exist within the Organisation (Scott & Caress, 2005; Schein, 2004) for learning styles to be beneficial.

In summary, the Author concludes that research aim one has been achieved through a comprehensive, critical review of literature relating to Leadership and Clinical Leadership. This literature review forms the basis of the conceptual model (Figure 2.5) which is used to test the subsequent aims of the research.

### **5.3.2 Aim Two: To Investigate NHS Wirral's Provider Services Current Understanding of Clinical Leadership**

For the purpose of clarity within this aim, the Author structures the conclusions to the key elements contained within the conceptual model (Figure 2.5) relating to: leadership theory, leadership qualities, learning and development and culture.

#### **5.3.2.1 Leadership Theory**

When identifying the extent to which NHS Wirral's Provider Services understands Clinical Leadership, it is clear that there is an understanding of leadership in its broadest sense. Evidence presented by both interviewees and focus group participants (Chapter Four: 4.3.1 & 4.4.1) concurs with the Traits Theory approach (Jung, 1923; Charan, 2007) and with Bennis and Goldsmith's (2003) view that leadership consists of qualities such as vision, empathy and integrity, therefore supporting the basis of the conceptual model (Figure 2.5).

Examination of the level of understanding regarding what Clinical Leadership is highlights that both interviewees and focus group participants have insight into what constitutes Clinical Leadership as responses such as "*Delivery of high quality services*" and "*Improving patient care*" mirror the view of Millward and Bryan (2005).

### 5.3.2.2 Leadership Qualities

In analysing the data collected (Chapter Four: 4.3.2 & 4.4.2) it is evident that both interviewees and focus group participants possess an understanding of the qualities and attributes of Clinical Leadership, which concurs with the work of Cook and Leathard (2004). However, the interviewees' responses are more detailed and relate to the NHS Leadership Qualities Framework (Institute for Innovation and Improvement, 2006), which the Author suggests may be due to five out of the six interviewees having undergone assessments directly related to this framework in the preceding three years.

The current ethos of the NHS is built upon utilising the leadership skills of those who work in its clinical services – Doctors, Nurses, Therapists. Elements of current literature suggest that effective Clinical Leadership may only occur when the individual involved is from a clinical background (Kahn, 2003; Willcocks, 2005) and that an individual may only clinically lead the professional group they represent e.g. Medical Director represents Doctors. The Author finds that this dimension whilst not reflected in the Conceptual Model (Figure 2.5) is a view supported by the majority of focus group participants.

Whilst evidence from the semi-structured interviews highlights a requirement for "*Clinical credibility*" in Clinical Leadership, a conflicting view is expressed by interviewees that suggests, Clinical Leadership is not only exhibited by those individuals with a clinical qualification. The Author suggests that this may reflect the professional backgrounds of the interviewees, as three out of the six interviewees possess a clinical qualification of which only one is required to possess this qualification for the position they currently hold e.g. Director of Nursing is a qualified Nurse. Indeed it is apparent from the evidence gained that the interviewees view Clinical Leadership in terms of the skills and qualities possessed by the individual rather than their clinical background, a view that is supported in the literature (Cook & Leathard, 2004; Jasper & Jumaa, 2005).

The view of the interviewees is in direct contrast to that of the focus group participants who mirror the views of Kahn (2003) and Willcocks (2005). The Author postulates that this may be due to the participants' clinical background, as eight of the ten participants possess a clinical qualification and manage a service they are clinically qualified for e.g. Head of Physiotherapy is a qualified Physiotherapist. Although, it should be acknowledged that evidence from the focus group does show that there are two Heads

of Clinical Services who do not possess clinical qualifications and are managing clinical services, an issue which caused much debate in the focus group. Evidence from the focus group shows that whilst initially the majority suggest that a clinical qualification is essential in Clinical Leadership, when challenged by a non-clinical Head of Service this view was altered to acknowledge that skills and qualities of individuals may be more relevant in Clinical Leadership. However, the Author suggests a note of caution when reviewing this conclusion in that the changing of the initial view to one that is perceived more acceptable to the group may invalidate the findings due to social desirability bias (Krueger & Casey, 2009; Hayes, 2007).

### **5.3.2.3 Learning and Development**

The NHS Leadership Qualities Framework (Institute for Innovation and Improvement, 2006), sets standards for Clinical Leadership within today's NHS and is based on a collective group of characteristics, behaviours, qualities and attributes expected of existing and aspiring leaders. Evidence from the semi-structured interviews (Chapter Four: 4.3.4) supports the framework's inclusion within the conceptual model (Figure 2.5), as it is evident that interviewees who are Director/Chief Executive level have been supported in their development as Clinical Leaders, through this framework and attendance on an "Aspiring Directors" course. In addition, one interviewee has gained an MBA which Schultz and Pal (2004) suggest can prove invaluable in the leading of Healthcare Organisations.

Little evidence is presented (Chapter Four: 4.4.4) that suggests participants within the focus group who are Heads of Clinical Services and therefore middle managers are being supported to develop Clinical Leadership skills. Learning and development accessed by this group appears to be predominantly management focused and is limited regarding Clinical Leadership development. Interestingly evidence is presented that suggests there is Clinical Leadership development available to this group through Strategic Health Authority modules but that this is restricted to those staff from a nursing background. The Author finds no evidence within current literature to support this rationale.

Significantly, the literature relating to Clinical Leadership (Crisp, 2001; Hewison & Griffiths, 2004; Jasper & Jumaa, 2005) reflects that Clinical Leadership must occur at all levels of the organisation for it to impact on service delivery and can only be delivered if staff are supported in their leadership development. However, it is clear

from evidence presented that little attention is paid to the leadership development of middle managers within NHS Wirral's Provider Services. This supports the argument (Cabinet Office, 2001; NHS London, 2008; Maddock, 2002) that there is limited learning and development available for middle managers to be effective leaders and deliver change.

#### **5.3.2.4 Culture**

In order to transform and modernise services within the NHS a receptive and positive culture must exist within the Organisation (Scott & Caress, 2005). The Author finds this to be present to a lesser degree within the findings of both the semi-structured interviews and focus group (Chapter Four: 4.3.5 & 4.4.5). However, what is clearly evident from the semi-structured interviews is the perception of the interviewees that the Author's position as Clinical Director will directly influence the Organisation's culture regarding Clinical Leadership. This view conflicts with current literature regarding Clinical Leadership which supports the encouragement of ownership and empowerment at all levels within an Organisation, as the transformation of the NHS will not occur unless the majority of employees at all levels are empowered to be leaders (Jasper & Jumaa, 2005).

In addition, this research considers the current workforce's perception of Clinical Leadership. It is widely acknowledged (Schein, 2004; Scott & Caress, 2005; Jasper & Jumaa, 2005) that in the drive for performance improvement an understanding of organisational culture and professional subcultures is required, so as to ensure effective engagement with all staff and the achievement of Organisational goals. Clearly evident from both the semi-structured interviews and focus group findings is the lack of understanding of the wider workforce's perception of Clinical Leadership and its potential role in the engagement of staff and ultimately achievement of Organisational goals.

In summary, the Author concludes that research aim two has been achieved through the presentation of findings which demonstrate NHS Wirral's Provider Services current understanding of Clinical Leadership.

### **5.3.3 Aim Three: Determine the Influence of Clinical Leadership on the Delivery of NHS Wirral's Provider Services**

The Author structures the conclusions to this aim to reflect the key elements contained within the conceptual model (Figure 2.5) relating to; competitive advantage, facilitation of change and development of a learning organisation.

#### **5.3.3.1 Competitive Advantage**

Today's NHS faces the challenge of providing high quality healthcare in a changing financial climate and increasingly demanding marketplace, where there is real focus upon achieving competitive advantage, business objectives and performance targets (DH, 2010). Within this element of the conceptual model (Figure 2.5), it is clear that the themes emerging from the data collected (Chapter Four: 4.3.3 & 4.4.3) are limited and predominantly focused on improvements in patient care and the delivery of services.

Competitive advantage (Porter, 1980) is how the Organisation achieves differentiation from the competition through distinctive levels of service, product range and quality. Minimal evidence is offered from both the semi-structured interviews and focus group to support this view, with limited reference made to the possible influence that Clinical Leadership may have on competitive advantage.

Some evidence is presented regarding the link between service efficiencies and financial improvements which supports the view of Paauwe and Boselie (2003) that efficient services can result in cost leadership. However, the Author finds that this is insufficient to claim any robust conclusions.

#### **5.3.3.2 Facilitate Change**

In analysing the data in relation to this element of the conceptual model (Figure 2.5) it is clear that evidence is presented from both the semi-structured interviews and focus groups (Chapter Four: 4.3.1 & 4.4.3) that suggests a key attribute of Clinical Leadership is the leading of change, a view mirrored in the current literature (Daft, 2008; DH, 2009a). Evidence from both groups supports the view that Clinical Leadership is a key enabler to sustainable change in the way in which healthcare is delivered (DH, 2009a).

However, no evidence is found to support Daft's (2008) view that people often assume that leading change is only restricted to those in positions of authority or identified leaders.

### **5.3.3.3 Learning Organisation**

In drawing together the findings within this element of the conceptual model (Figure 2.5) it is clear that the individual learning styles of both the interviewees and focus group participants (Chapter Four: 4.3.4 & 4.4.4) is predominantly reflective in nature, which may support the development of a Learning Organisation. This is a view supported by Jasper and Jumaa (2005), who recognise the importance of both the individual and organisation learning together by reflecting on past events. Whilst no evidence is found in the findings to support the development of a Learning Organisation and its importance in the achievement of organisational success (Daft, 2008), the Author acknowledges that the findings may be limited due to the style of question asked of both groups, as this was restricted to what was the individual's learning style and did not expand to include views on NHS Wirral's Provider Services as a Learning Organisation.

However, evidence within both groups supports the belief that Clinical Leadership involves the need to reflect on behaviours (Jasper & Jumaa, 2005) and that people learn more from their experiences when they reflect on them (Kolb, 1983; Hughes et al, 2009). With the majority of interviewees and focus group participants exhibiting a reflective learning style, the Author postulates that potentially this may support the development of a Learning Organisation and organisational success, a view echoed by Daft (2008) who suggests that the learning capacity of an organisation and its success depends primarily on the individual learning style of its members.

In summary, the Author concludes that research aim three has been partially achieved as evidence presented suggests that Clinical Leadership may influence the delivery of NHS Wirral's Provider Services. However, the Author acknowledges that this evidence is limited and makes recommendations (5.7) regarding further opportunities to explore the influence of Clinical Leadership on the delivery of NHS Wirral's Provider Services.

## **5.4 Conclusions About the Research Question**

The research question for this study is "*To what extent does Clinical Leadership influence the delivery of NHS Wirral's Provider Services?*" Following data collection and analysis, the Author concludes it has been clearly demonstrated, that at the time of this study, knowledge of what constitutes Clinical Leadership and the qualities required to develop this within an organisation are evident within NHS Wirral's Provider

Services. The extent to which this may influence the delivery of NHS Wirral's Provider Services is difficult to ascertain, although there is some evidence that Clinical Leadership within NHS Wirral's Provider Services may improve the delivery of patient services, achievement of organisational goals and to a lesser degree competitive advantage.

The Author does acknowledge that there is a lack of organisational understanding relating to Clinical Leadership and its potential influence in the delivery of NHS Wirral's Provider Services. This is clearly evident from the findings presented and predominantly relates to the absence of Clinical Leadership learning and development for middle managers and a sustained presence of a supportive organisational culture relating to Clinical Leadership.

In conclusion, the Author believes that there is no "Yes" or "No" answer to the research question, but rather the research has provided partial evidence regarding the potential influence of Clinical Leadership on the delivery of NHS Wirral's Provider Services. In addition, the Author recognises that the presence of a new political agenda relating to the provision of healthcare and development of Clinical Leadership may impact on the results obtained and as such recommendations are made within Chapter Six to explore the influence of Clinical Leadership further within NHS Wirral's Provider Services.

## **5.5 Overall Conclusions**

The Author suggests the following conclusions as a result of this research study and the findings discussed in Chapters Four and Five.

Firstly, evidence shows an understanding within NHS Wirral's Provider Services of what skills and qualities constitute Clinical Leadership and how this may support the achievement of organisational goals and delivery of quality healthcare services.

Secondly, evidence suggests that there appears to be a lack of Clinical Leadership development and support within the middle management tier of NHS Wirral's Provider Services.

Thirdly, there is limited evidence of a supportive culture in relation to Clinical Leadership and the perception of the wider workforce's view of Clinical Leadership.



Finally, there is evidence to suggest individual learning styles may potentially influence NHS Wirral's Provider Services in relation to the development of a Learning Organisation and competitive advantage.

## **5.6 Limitations of the study**

This research is limited to two tiers of management within NHS Wirral's Provider Services (Directors/Chief Executive & Heads of Clinical Services) and is a snap shot taken at a particular time of change and uncertainty. Consequently, the research is not applicable to other NHS Organisations and is unlikely to offer a long term perspective of NHS Wirral's Provider Services, which is likely change in the foreseeable future. As a result opportunities for further research are discussed in the next section and recommendations are made in Chapter Six for further developments.

## **5.7 Opportunities for Further Research**

The Author suggests that there are a number of ways in which this research could be further enhanced and developed.

Firstly, the research is cross-sectional and relates to NHS Wirral's Provider Services at a specific period of time of change. A longitudinal study may elicit more comprehensive evidence over a longer period of time regarding the influence of Clinical Leadership on the delivery of NHS Wirral's Provider Services.

Secondly, this research is limited to two tiers of management within NHS Wirral's Provider Services; an expansion of this research to include staff at all levels within NHS Wirral's Provider Services may provide a broader insight into the influence of Clinical Leadership on the delivery of NHS Wirral's Provider Services.

Thirdly, the use of quantitative instruments such as questionnaires may elicit more comprehensive and reliable evidence relating to the influence of Clinical Leadership on the delivery of NHS Wirral's Provider Services, as the presence of social desirability bias would be minimised.

Finally, whilst this research is cross-sectional and relates to NHS Wirral's Provider Services it may be useful to reproduce this research within an Acute Hospital Trust so as to ascertain the influence of Clinical Leadership on the delivery of different healthcare services.

## **6.0 Chapter Six – Recommendations**

### **6.1 Introduction**

This chapter satisfies research aim four, by making appropriate recommendations based on the research findings in Chapter Four and conclusions in Chapter Five.

### **6.2 Recommendations**

#### **6.2.1 Recommendation One**

The research suggests (5.3.2.1; 5.3.2.2; 5.5) that staff within NHS Wirral's Provider Services, are aware of the skills and qualities required for Clinical Leadership. The Author recommends that this knowledge should be supported and developed throughout NHS Wirral's Provider Services so as to encourage Clinical Leadership at all levels of the Organisation. This may be achieved through the development of a robust Clinical Leadership learning and development programme.

#### **6.2.2 Recommendation Two**

Linked to Recommendation One, evidence presented (5.3.2.2; 5.5) highlights a lack of Clinical Leadership learning and development support to the middle management tier of NHS Wirral's Provider Services. The Author recommends that NHS Wirral's Organisational Development Team take the lead in the design and implementation of a robust Clinical Leadership development programme that incorporates elements of the Leadership Qualities Framework (Figure 2.3; Institute for Innovation & Improvement, 2006). Whilst costs will be incurred for the development and implementation of such a programme and are estimated at approximately £22,000 initially (includes design, resources required, attendance and external evaluation), the Author suggests that if evaluated successfully then this programme may provide a source of income to NHS Wirral's Provider Services as other NHS Organisations may wish to purchase such a programme.

#### **6.2.3 Recommendation Three**

Successful implementation of Recommendations Two and Three will potentially lead to the development and embedding of a supportive organisational culture regarding Clinical Leadership. As shown (5.3.2.4; 5.5) there is some evidence of a supportive culture within NHS Wirral's Provider Services regarding Clinical Leadership.

However, this currently appears to be limited to the top tier of management (Director/Chief Executive) and is viewed as being the sole responsibility of the Author in their post as Clinical Director. The Author recommends that in the role of Clinical Director, they work in partnership with all NHS Wirral's Provider Services staff to develop and embed a supportive culture regarding Clinical Leadership. This should form part of the work plan for the Author during 2010/11 and focus on ways in which staff can be supported in their Clinical Leadership development. The Author should consider development of the following:

- Clinical Leadership forums where good practice and ideas can be shared across all staff groups.
- Continuous engagement with staff via media communications e.g. websites, newsletters.
- Visit frontline staff, so as to gain an in-depth understanding of issues affecting staff and how Clinical Leadership can be developed within NHS Wirral's Provider Services.

#### **6.2.4 Recommendation Four**

Limited evidence from this research suggests (5.3.3.3; 5.5) that the development of NHS Wirral's Provider Services as a Learning Organisation will influence the achievement of organisational goals and possible competitive advantage. The Author therefore, recommends that in their role as Clinical Director that they should work with the Director of Organisational Development to explore this opportunity further. This should form part of the Author's work plan for 2010/11 and may involve further research to understand how the development of Clinical Leadership throughout NHS Wirral's Provider Services will yield positive benefits for the Organisation.

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## Appendix One: Invite Letter to Semi-Structured Interview



Dear

***Re: MBA Dissertation: “Clinicians in Leadership: To What Extent Does Clinical Leadership Influence the Delivery of NHS Wirral’s Provider Services?”***

I am writing to confirm your agreement to participate in a semi-structured interview regarding the above topic. The interview will take place on (DATE), at (TIME) and (VENUE).

As previously discussed I am currently completing my final year MBA dissertation regarding Clinical Leadership and its potential influence on the delivery of NHS Wirral’s Provider Services, as such the results of this interview may be used within the findings section of the final MBA submission.

The interview will last approximately 45 minutes and will be recorded with your permission. I will also take notes throughout to ensure I capture all of your responses. Please note that all responses will be anonymised and treated in the strictest confidence. In addition all transcripts and notes following the semi-structured interview will be destroyed on submission of the final MBA dissertation.

Please note that you retain the right to refuse to answer any question and can terminate the interview at anytime.

I enclose a copy of the interview questions for you perusal and look forward to interviewing you on (DATE and TIME). If you require any further information please do not hesitate to contact me on 0151 643-5316 or email; [lisa.cooper@wirral.nhs.uk](mailto:lisa.cooper@wirral.nhs.uk).

Yours sincerely,

Lisa Cooper

**Clinical Director of Provider Services**

## **Appendix Two: Semi-Structured Interview Questions**

### **1. Leadership Theory**

- a) Can you describe what leadership is?
- b) Can you describe what Clinical Leadership is?

### **2. Leadership Qualities**

- a) Can you describe what traits Leaders exhibit?
- b) What do you think are the main attributes exhibited by Clinical Leaders?
- c) What qualities do you think effective Clinical Leaders possess?

### **3. Benefits of Clinical Leadership**

- a) What benefits do you believe Clinical Leadership can bring to the Individual?
- b) What benefits do you believe Clinical Leadership can bring to the Service/Team?
- c) What benefits do you believe Clinical Leadership can bring to the Organisation?

### **4. Learning and Development**

- a) What leadership development and training have you received
- b) Can you describe your learning style?

### **5. Culture**

- a) From your own experience how do you believe the current workforce perceives Clinical Leadership?

### **Appendix Three: Invite Letter to Focus Group**



Dear

***Re: MBA Dissertation: “Clinicians in Leadership: To What Extent Does Clinical Leadership Influence the Delivery of NHS Wirral’s Provider Services?”***

I am writing to invite you to participate in a focus group regarding the above topic. The focus group is arranged for Wednesday 10<sup>th</sup> March 2010 at 3.30pm, Bevan Suite, Old Market House, Wirral. Refreshments will be provided.

I am currently completing my final year MBA dissertation regarding Clinical Leadership and its potential influence on the delivery of NHS Wirral’s Provider Services, as such the results of this focus group may be used within the findings section of the final MBA submission.

The focus group will last approximately 90 minutes and will be recorded with your permission. My assistant Julie Sheldrick, will take notes throughout to ensure I capture all of your responses. Please note that all responses will be anonymised and treated in the strictest confidence. In addition all transcripts and notes following the focus group will be destroyed on submission of the final MBA dissertation.

Please note that you retain the right to refuse to answer any question and can leave the focus group at any time.

Please can you confirm your attendance at the focus group by Monday 8<sup>th</sup> March 2010 by contacting me on 0151 643-5316 or email; [lisa.cooper@wirral.nhs.uk](mailto:lisa.cooper@wirral.nhs.uk).

Yours sincerely,

Lisa Cooper

**Clinical Director of Provider Services**

## **Appendix Four: Focus Group Questions**

### **1. Leadership Theory**

- a) Can you describe what leadership is?
- b) Can you describe what Clinical Leadership is?

### **2. Clinical Leadership Qualities**

- a) What do you think are the main attributes exhibited by Clinical Leaders?
- b) What qualities do you think effective Clinical Leaders possess?

### **3. Benefits of Clinical Leadership**

- a) What benefits can Clinical Leadership bring to the Individual, Service/Team and Organisation?

### **4. Learning and Development**

- a) What leadership development and training have you received
- b) Can you describe your learning style?

### **5. Culture**

- a) From your own experience how do you believe the Organisation perceives Clinical Leadership?



## Appendix Five: Research Approval Letter



Lisa Cooper  
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Tel: 0151 651 3935  
10 November 2009

**Re: Proposed MBA dissertation; "Clinicians in Leadership: To what extent does Clinical Leadership influence the delivery of NHS Provider Services"**

Dear Lisa,

I write to confirm that the above study has received NHS Wirral R&D approval. The project may be defined as an evaluation of existing clinical leadership and as such will **not** require NHS ethical approval. Following approval, the details of the project are updated on the NHS Wirral R&D database.

I wish you every success in the continued development of your research and look forward to receiving the final dissertation for the study. If you require any further information or assistance please do not hesitate to contact me on 0151 651 3935.

Yours sincerely